Care Quality Commission

Frewco Services Limited

Community Life Choices Head Office

Inspection report

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Date of inspection visit: 25/01/2016
Date of publication: 01/04/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Community Life Choices is a Domiciliary Care Agency providing care and support to people in their own homes. The agency provides services to people with a range of care needs including older people, people with physical disabilities and people with mental health needs. At the time of the inspection the agency was providing approximately 250 hours of care and support per week and employed 20 care staff.

The agency is managed from a well-equipped office in the Docklands area of Preston. The last inspection of the service took place on 18th November 2015. At this time the service was awarded an overall rating of 'Requires Improvement.' We found breaches in regulations relating to safe care and treatment, safeguarding people from abuse and improper treatment, receiving and acting on complaints, good governance and safe staffing. We told

Summary of findings

the provider to take action to address these issues and provide us with an action plan stating when and how they intended to achieve compliance with the regulations. At the time of this inspection, the provider was still within the allowed timescales for developing the action plan. As such, it had not yet been provided.

Following the inspection carried out on 18th November 2015, we received concerns from four people who used the service and a community professional. As a result of the concerns received, we carried out a further inspection on 25th January 2016. This inspection was unannounced.

This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Community Life Choices Head Office on our website at www.cqc.org.uk

The registered manager assisted us throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager of this service was also the provider.

People who used the service raised a number of concerns regarding the service. These included concerns about care workers arriving late or in some cases, not arriving at all. All four people also told us that care workers often cut their visits short and didn't stay for the right amount of time.

People also expressed concerns about the competence of some carers to move and handle them safely. Two people told us they had experienced situations where care workers had caused them discomfort because they hadn't moved them in the correct way. Both people told us they had reported their concerns to managers at Community Life Choices but didn't feel appropriate action had been taken.

People told us they didn't feel comfortable when expressing concerns about the service to members of the management team. Some described receiving unhelpful responses and said at times they had been treated disrespectfully or in an unkind manner by managers. However, all those we spoke with told us that there were some care workers who were very kind, helpful and caring.

We found evidence that allegations of abuse were not always reported in line with the correct procedures and managers did not always take the appropriate action to safeguard people who made allegations. During this inspection we found evidence that three allegations of abuse or neglect had been made by people who used the service but had not been reported.

We found evidence that complaints made by people who used the service were not always taken seriously or investigated properly.

Evidence was also found to support the concerns people had raised with us about the way the management team communicated with them. We saw examples of very poor communication, which was unhelpful and unprofessional.

We identified serious concerns about the management of staff rotas. We found a number of examples of badly organised staff rotas which were unmanageable because care staff were frequently rostered to be supporting more than one person at the same time. This supported the information we received from people regarding the unreliability of their service.

We found ongoing breaches of the Health and Social Care Act 2014 relating to dignity and respect, safeguarding people from abuse and good governance.

Following this inspection the overall rating for this service is 'Inadequate' and the service has been placed in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

Summary of findings

preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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 concerns identified during this inspection were reported to the Local Authority Safeguarding team and the Local Authority Contracts Commissioning team.

You can see what action we have taken at the end of the full version of this report.

Summary of findings

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.

Arrangements for protecting people from abuse and improper treatment were inadequate. Allegations of abuse were not always referred to the appropriate authorities or investigated thoroughly.

There were ineffective arrangements in place to ensure that staff had the correct skills and knowledge to support people safely.

People who used the service were not always treated in a respectful and dignified manner.

Is the service effective?

Requires improvement

The service was judged as requiring improvement in this domain at the comprehensive inspection carried out on 18th November 2015. This domain was not re-assessed during this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Community Life Choices Head Office on our website at www.cqc.org.uk

Is the service caring?

Requires improvement

The service was judged as requiring improvement in this domain at the comprehensive inspection carried out on 18th November 2015. This domain was not re-assessed during this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Community Life Choices Head Office on our website at www.cqc.org.uk

Is the service responsive?

Requires improvement

The service was judged as requiring improvement in this domain at the comprehensive inspection carried out on 18th November 2015. This domain was not re-assessed during this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Community Life Choices Head Office on our website at www.cqc.org.uk

Is the service well-led?

Inadequate

The service was not well led.

Arrangements for organising people's services were not effective. People did not receive a reliable or consistent service.

Summary of findings

Managers failed to take people's concerns seriously and sometimes communicated with people in an unhelpful manner.

The arrangements to monitor safety and quality across the service were not effective. This meant that risks to people's health, safety and wellbeing were not always identified or addressed and opportunities for improvement were consistently missed.

Community Life Choices Head Office

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to follow up on a number of concerns we had received.

The inspection took place on 25 January 2016. The inspection was unannounced which meant the provider was not aware it would be taking place until we arrived.

The inspection team consisted of two adult social care inspectors.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who used the service. A Provider Information Return (PIR) was not requested for this inspection.

We spoke with 4 people who used the service or their main carers. We also spoke with four staff members, including the registered manager, the care manager and two care workers.

We carried out a pathway tracking exercise. This involved us examining the care records of three people closely, to assess how well their needs and any risks to their safety and wellbeing were addressed.

We consulted seven community professionals throughout the inspection, including professionals from the local authority safeguarding team and the Local Authority Commissioning Department. We received feedback from two of them.

We reviewed a variety of records, including staff personnel and training files, staff rotas and records of complaints.

Inadequate

Is the service safe?

Our findings

During the last inspection carried out on 18th November 2015, the service was rated inadequate for this domain. We identified concerns in relation to the arrangements for safeguarding people who used the service from abuse and improper treatment. Following that inspection we were made aware that two people had made allegations regarding unsafe moving and handling, which they had stated had caused them harm. In these circumstances, safeguarding alerts should have been raised by the service. However, when we investigated these issues further, we found evidence that the allegations had been raised with a member of the management team but safeguarding procedures had not been followed.

We were able to establish that neither allegation had been referred to the Local Authority Safeguarding Team. In terms of the staff members supporting them, no immediate action had been taken to safeguard the people involved from further harm and neither incident had been properly recorded. We also found evidence that another allegation of neglect, had been raised by a person who used the service, which again had not been referred to the safeguarding authority.

These findings demonstrated an ongoing breach of Regulation 13 (1)(2)& (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four people who contacted us raised concerns about the way some members of the management team communicated with them. These people all felt that when they raised concerns, they were responded to in a poor manner. These issues were investigated by the local authority safeguarding team. During the course of this investigation, evidence was seen that supported these concerns. Some text message communication with one person who used the service by a member of the management team was seen to be disrespectful and unpleasant. During the inspection we saw further evidence of text message communication between another person who used the service and a member of the management team. The text message back to this person was unhelpful and did not address their concerns. This response had caused the person to become anxious.

These findings demonstrated an ongoing breach of Regulation10(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the last inspection we identified concerns regarding the safe care and treatment of people who used the service and found the service to be in breach of regulations relating to safe care and treatment. We received a number of concerns from people who used the service regarding the skills of some staff to support people with moving and handling needs safely. We looked at the training provided for some carers supporting people with complex moving and handling needs. We found evidence that three staff members who were regularly supporting people who required support to transfer with the use of a hoist had not been provided with practical training in moving and handling.

There was no system in place to ensure that care staff allocated to support people with complex moving and handling needs were adequately trained. This meant that not all possible steps to protect people from the risks of unsafe care had been taken.

These findings demonstrated an ongoing breach of regulation 12(1)(2)(a)(b)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

We carried out a comprehensive inspection of this service on 18 November 2015 and awarded the service a rating of requires improvement for this domain. After that inspection we received concerns in relation to the areas of safe and well- led. As a result we undertook this focused inspection to look into those concerns. This report only covers our findings in relation to those domains. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Community Life Choices Head Office on our website at www.cqc.org.uk.

Requires improvement

Is the service caring?

Our findings

We carried out a comprehensive inspection of this service on 18 November 2015 and awarded the service a rating of requires improvement for this domain. After that inspection we received concerns in relation to the areas of safe and well- led. As a result we undertook this focused inspection to look into those concerns. This report only covers our findings in relation to those domains. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Community Life Choices Head Office on our website at www.cqc.org.uk.

Requires improvement

Is the service responsive?

Our findings

We carried out a comprehensive inspection of this service on 18 November 2015 and awarded the service a rating of requires improvement for this domain. After that inspection we received concerns in relation to the areas of safe and well- led. As a result we undertook this focused inspection to look into those concerns. This report only covers our findings in relation to those domains. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Community Life Choices Head Office on our website at www.cqc.org.uk.

Inadequate

Is the service well-led?

Our findings

During the last inspection carried out on November 18th 2015 the service were awarded a rating of 'requires improvement' for this domain. The provider was found to be in breach of Regulation 17 - Good governance, because they had failed to implement systems to effectively monitor the safety and quality of the service.

Following the inspection carried out on 18th November 2015, four people contacted us and expressed concerns about the reliability of the service. People reported regular experiences of carers arriving late, not staying for their commissioned time and on some occasions, not arriving at all.

During this inspection we examined the staff rotas of four care workers. We looked at their allocated calls for a period of eight weeks. We found evidence of regular double booking and sometimes treble booking of care workers. This meant that care workers' rotas sometimes showed them as being at two or sometimes, three calls at the same time, making their care duties physically impossible to complete. These findings supported the information provided by people who used the service regarding their experiences of late, short or missed calls. We spoke with one carer about the rotas. They told us they tried to 'muddle through as best they could'. They told us they were sometimes able to make up time, if people didn't require their whole allocated time, but said they were regularly late and that this was a 'massive source of anxiety'.

Arranging services in this manner meant that people were at risk of not receiving the care they required to keep them safe. In discussion, the provider advised that members of the management team would support staff when they could not get through all their calls. However, it was difficult to establish how this arrangement could be effective, in light of the frequency of the double booking.

We also had serious concerns regarding the length of shifts some staff members worked. When viewing the staff time sheets we saw a number of examples of staff working 16 hour shifts, in some cases with only one 45 minute break, or two thirty minutes break.

The arrangements for managing rotas did not support a reliable, safe or consistent service. They also demonstrated that the provider had failed to take account of people's previous feedback about their experiences of late, missed or short calls. We saw that one person had made a complaint about their carers often being late. A member of the management team had responded to the complaint by stating the issue was due to the location in which they lived, as this was an area known to experience traffic build ups. However, staff time sheets showed that this person's calls were often double booked which was likely to be the true cause.

Following the inspection the provider was requested to provide evidence that effective arrangements were in place to ensure people's call could be arranged. This information was not provided within the timescales requested. We were then informed by the Local Authority that the provider had withdrawn services from five people who used the service, without providing any notice. This resulted in people not having the correct care support in place, in some cases for several days.

We viewed records relating to a complaint made by a person who used the service. These were described on the complaint record as 'lots of issues', which had been received by text message. We saw that despite the fact the complainant had raised a number of issues, no attempt had been made to meet with them to discuss them in detail. In addition, a response to the complainant had been posted out the next day stating that the issues had been fully investigated and largely not upheld. It was difficult to establish how a thorough investigation could have been carried out in such a short time scale.

People we spoke with told us they did not feel their complaints were taken seriously. People told us they did not feel comfortable in raising concerns as they found members of the management team could be unhelpful in these circumstances. One person said that they had found a manager to be so rude and disrespectful when they had tried to raise a concern they had 'been in shock.' As part of a local authority safeguarding investigation and this inspection, we were shown some communication by a member of the management team with two people who used the service which supported this information. In one case, communication was extremely unprofessional and discourteous. In another the communication was seen to be unresponsive and unhelpful.

Inadequate

Is the service well-led?

One person we spoke with told us in their opinion, their family member had received a 'very appalling service.' This person told us they had raised a number of complaints with the agency. However there was no record of any concerns being raised by this person.

The lack of effective arrangements to provide a safe, reliable service and protect people from unsafe, ineffective care and failure to respond to feedback form people who used the service demonstrated an ongoing breach of Regulation 17 (1)(2)(a)(b) 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 legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had failed to ensure that people were treated with dignity and respect and that their autonomy was supported. 10(1)(2)(a)(b)(c)

The enforcement action we took:
Due to the overall inadequate rating awared following this inspection this service has been placed in special measures. We are taking action against the provider and will report on this action when it is complete.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had failed to ensure that safe care was provided by assessing the risks relating to people's care and taking all practicable measures to mitigate such risks, including arrangements to ensure people providing care have the correct skills to do so. 12 (1)(2)(a)(b)(c)

The enforcement action we took:
Due to the overall inadequate rating awared following this inspection this service has been placed in special measures. We are taking action against the provider and will report on this when it is complete.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had failed to ensure the effective operation of systems and processes to protect people from abuse. 13 (1)(2)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Due to the overall inadequate rating awared following this inspection this service has been placed in special measures. We are taking action against the provider and will report on this when it is complete.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had failed to implement systems to effectively monitor the safety and quality of the service. 17 (1) (2) (a) (b) (e) (f)

The enforcement action we took:
Due to the overall inadequate rating awared following this inspection this service has been placed in special measures. We are taking action against the provider and will report on this when it is complete.