FDR Social Care Ltd

FDR Social Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
FDR Social Care is a domiciliary care agency providing personal care to people in their own homes. At the time of our inspection there were 2 people using the service.

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.

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

Right Support:
Risks to people had been assessed but mitigating strategies had not always been implemented. Staff did not always understand or follow safeguarding procedures and they did not demonstrate they knew how to protect people from potential abuse and harm. Staff did not always support people with dignity and respect; staff had to be reminded to preserve people's dignity.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff ensured they asked consent from people before supporting them. Staff understood people's rights to refuse care.

People were involved in their care planning. People's care plans included information which reflected their protected characteristics under the Equality Act.

Right Care:
The provider failed to ensure staff were recruited using safe recruitment practices. The provider failed to ensure staff received adequate induction, training or supervision to provide person centred, safe care to people. People were at risk of receiving care from staff that were not of good character or had the skills and knowledge to provide safe care.

People's records were not always accurate as they did not reflect the care given by the staff who provided the care. People's care plans did not include information on how staff were to provide care to mitigate the known health care risks. People's care plans were not always reviewed when people's needs changed.

Staff did not always demonstrate kindness as they took advantage of people's vulnerability.

Staff could access healthcare professionals if needed. Staff supported people with meal preparation as

required.

Right Culture:
There was very poor managerial oversight of safeguarding, incidents, complaints, people's records, rotas, staff records and audits. The provider failed to have systems to assess, monitor, mitigate risks and improve the service.

People, relatives and staff had been asked to feedback on the service, but these had not been analysed or used to drive improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 24 February 2022 and this is the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Enforcement and Recommendations
We have found evidence that the provider needs to make improvements. Please see the Safe, Caring and Well Led sections of this full report.

We have identified breaches in relation to safeguarding, care planning, staffing, recruitment, maintaining dignity and respect and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

FDR Social Care

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 1 inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses.

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
We gave the service 48 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 13 March 2023 and ended on 24 March 2023. We visited the location's office on 15 March 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. We used the information the provider

sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 1 person and 1 relative of a person who used the service about their experience of the care provided. We spoke with 4 members of staff including the registered manager.

We reviewed a range of records. This included 2 people's care records and 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management and oversight of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- The provider failed to carry out safe staff recruitment procedures. One person was receiving care from a member of staff that had not been subject to the provider's recruitment procedures between 20 December 2022 and 2 February 2023. The person told us they did not feel safe when they realised this had happened. This placed people at risk of harm from staff that had not been proven to have the suitable character, skills, knowledge, training and support to provide their care.
- From 2 February 2023 a member of staff was providing care unsupervised without a clear Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We brought this to the attention of the provider who arranged for this member of staff to work under supervision. This placed people at risk of receiving care from staff who may not be of a suitable character.
- The provider failed to keep accurate records of staff employment or deployment including dates when staff commenced employment and when staff received their induction. This meant people were at risk of receiving care from staff who had not been proven to be suitable to provide their care.
- There were not enough staff employed using safe recruitment practices to provide all the care people required to meet their needs. This placed people at risk of not receiving their planned care; placing them at risk of poor skin integrity and missed meals.
- The provider failed to consider one person's needs when recruiting and deploying staff. For example, staff had not been introduced to people living with autism in a timely way; this caused anxiety and distress for people who were introduced to new care staff at the last minute.

The provider failed to follow safe recruitment practices which placed people at risk of receiving care from staff who have not been proven to be of good character. This placed people at risk of harm. This was a breach of regulation 19 (1) (2) (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

- 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 the abuse would not be recognised or acted upon.
- The provider failed to effectively investigate or contribute to safeguarding investigations. Where the safeguarding team and CQC asked for information relating to a safeguarding concern relating to staff not being recruited safely, the provider failed to provide accurate information. This meant people were at risk of ongoing abuse as the known safeguarding concerns had not been suitably investigated or resolved.
- Although the provider's safeguarding policy stated how to report a safeguarding concern to the local

authority, the registered manager failed to report the safeguarding concerns. This meant people were at risk of ongoing abuse as the provider did not report concerns to the relevant authorities to help prevent future incidents.
● Staff had received safeguarding training but there was no evidence their competency had been checked. Although staff told us they understood their role in safeguarding people, staff failed to do so in practice. Where staff had identified safeguarding issues, these had not been recorded at the time, or reported to the manager as required in their safeguarding policy. When the manager was alerted to the incidents, they failed to recognise the incidents needed to be reported to the safeguarding team. CQC raised two safeguarding concerns during the inspection. This placed people at risk of ongoing abuse as the provider failed to follow their policy and failed to report the concerns.
● The provider had a procedure to record safeguarding incidents that could be reviewed, however, they failed to use their system to record these.

The provider failed to have sufficient systems in place to protect people from abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13 (1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely
● The registered manager failed to assess all risks associated with incidents or people's health conditions. This meant people were placed at risk of harm as care staff did not have care plans or instructions on how to mitigate these risks.
● The provider had a system to keep staff up to date with changes in people's care through messages and access to people's electronic records, however, these did not include all of the care required for people's health conditions. This placed people at risk of deteriorating health as staff did not have all the information they required to manage these health conditions.
● People's planned care did not include the administration of their medicines by staff. However, one person's risk assessment stated that staff should support them to take medicine for constipation and sign their medicines chart, but there was no medicines chart in place. The provider confirmed staff did not provide any medicines. This information contradicted information in their care plans.

The provider failed to have assessed all the risks to the health and safety of people or doing all that is reasonably practicable to mitigate any such risks. This placed people at risk of harm. This was a breach of regulation 12 (2) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's environmental risks were assessed, and steps taken to mitigate these risks.
● Staff had received training in the management of medicines and there were medicines policies available to staff.

Learning lessons when things go wrong
● The provider did not use their systems to record accidents, incidents, safeguarding concerns or complaints. This meant they did not have the information they required to analyse and learn from these. People were at risk of continued incidents, safeguarding incidents or dissatisfaction of the service as the provider failed to have systems to learn from these.

Preventing and controlling infection
● Staff received training in infection prevention and control.

- Staff used personal protective equipment (PPE) to keep people safe.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider recorded when staff had received their induction but not all the records were accurate. This meant it was unclear when and whether staff have received the induction that has been recorded.
- The provider recorded when staff received training, however, the training dates were not accurate. The dates for training for a member of staff showed they had completed some of their training at the service 6 months before they commence employment. For a member of staff the provider had 3 different training dates for moving and handling, assessing mental capacity, deprivation of liberty safeguards, duty of care, communication and privacy and dignity. Staff told us they had many years of experience, but could not tell us when the training was carried out or when the training required updating.
- The provider's records for supervisions were not accurate. For one member of staff the supervision dates did not correlate with the dates of employment. It remains unclear when this supervision took place.
- Staff did not have the training or skills required to know how to manage people's specific needs such as Parkinson's disease, autism, and seizures. 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.

The provider failed to ensure staff had the competence, skills and experience necessary to carry out their roles. This placed people at risk of harm. This was a breach of regulation 19 (1) (2) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's care records contained information about people's medical history, but they failed to address how staff would support these.
- Staff prepared one person's meals; they ensured they prepared meals the person had chosen.
- Staff received training in food hygiene.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People and their relatives had been involved in the assessment process.
- The provider's pre-assessment of needs was comprehensive and gathered information from relatives and relevant professionals. People's protected characteristics under the Equality Act 2010 were considered. This included age, disability, gender reassignment and religion. However, the subsequent care plans did not consider all of the assessed needs.

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The service was working within the principles of the MCA. Staff understood the principles of the MCA.
- People's mental capacity to consent to their care and support had been assessed. Staff recorded at every visit they had sought people's consent before they had provided their care.
- There were no people subject to any restrictions placed upon them by the Court of Protection.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity ; Supporting people to express their views and be involved in making decisions about their care

- Staff had not always respected people's privacy or recognised people's vulnerability. On 1 occasion staff had asked a person receiving care to pass on their personal information to another care staff and the provider. A member of staff also regularly messaged a person using their personal phone. The provider failed to have a sufficient system for people to communicate with staff, placing people at risk of exploitation, and invading their privacy.
- Staff did not work in a way which respected people's privacy. For example, a person told us they knew information about another person receiving care because staff had told them.
- Staff did not always understand the importance of keeping accurate records. A member of staff had repeatedly recorded they had provided care when they had not. The provider failed to have a system to check people's care records were accurate placing people at risk of having inaccurate records of their care.
- Although staff had received training in equality and diversity, they failed to always show compassion and awareness of people's diverse needs. The provider failed to ensure staff had the skills and training to care for an autistic person and failed to have systems in place to introduce new staff in a way that met their specific needs.
- Relatives told us staff did not always respect and promote their family member's dignity and privacy, as staff were not always vigilant in closing the curtains before providing personal care and required prompting by family to do so.

The provider failed to treat people with dignity and respect. This placed people at risk of harm. This was a breach of regulation 10 Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider met with people and their families regularly to obtain feedback and discuss their plans of care.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans were not always reflective of people's current needs. Where people's needs had changed, the provider had not always assessed the risk or provided staff with the care plans on how to mitigate these risks. Where people's care plans had been updated, the information about how to manage the risk was not always relevant as the same information was repeated in many sections but did not relate to all the risks. This meant people were at risk of not receiving their planned care as staff did not have enough information on how to meet their needs.
- The provider met with people and their families to discuss their care at regular intervals. However, the provider failed to identify where care had not been planned to meet their needs. People were at risk of not receiving person-centred care as their care plans did not reflect how staff should meet their needs.
- The care plans did not include all people's protected characteristics for staff to provide person-centred care. The plans did not cover all of the aspects of people's lives such as health, independence, goals, skills and abilities, and guided staff on how best to support people. This meant autistic people were at risk of not having care that met their specific needs.

The provider failed to ensure people received care that met their needs and reflected their preferences. This placed people at risk of harm. This was a breach of regulation 9 (1) Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The provider failed to maintain a log of the complaints they had received or the actions they had taken. The provider did not have the information they needed to analyse the complaints or use the information to learn and improve the service.
- The provider had a complaints policy which included how to raise their concerns if people's complaints were not managed to their satisfaction.
- Where relatives had raised a concern, they told us this had been responded quickly and resolved the issue to their satisfaction.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's communication needs were assessed. The provider had experience in assessing people's communication needs and had systems in place to implement information in different formats if required.

End of life care and support

● At the time of the inspection, no one was receiving end of life care. Records showed people and their relatives had opportunities to discuss their end of life wishes.

● The management team told us end of life support plans would be completed when required, and with the involvement of relevant individuals and palliative health care professionals.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider was registered to provide care for people with a learning disability or autistic people; they are responsible for providing care that meet their needs. The negative culture within the service meant the provider failed to provide respectful and dignified care to autistic people. They failed to ensure staff had the training and support to follow the ethos, values, attitudes and behaviours required to provide person centred care. This meant autistic people's anxieties were increased and their health put at risk due to poor staff deployment, inconsiderate communication and inadequate staff training.
- The provider failed to have sufficient systems and processes in place to continually assess, monitor and review quality and safety of the service. They failed to have adequate managerial oversight of the care they provided, or the records of care, placing people at risk of harm. The provider told us they planned to expand their service, but they failed to have enough insight into the safety and effectiveness of the service they provided; people were at risk of harm due to the lack of embedded systems.
- The provider failed to have the systems and processes to check safe recruitment procedures were followed as they failed to recognise that people were at risk of harm if staff did not have a clear DBS check. They failed to check staff had received the training and supervision they required to carry out their roles. This placed people at risk of receiving care from staff that had not been proven to be of good character or have the skills and knowledge to provide safe care to meet people's needs.
- The provider failed to have sufficient systems to identify, record or report safeguarding concerns, incidents or complaints. They failed to have systems to check all risks and health conditions had been identified and plans in place to mitigate all the risks. People were put at risk of harm as the provider did not have sufficient systems in place to prevent harm.
- The provider failed to have accurate systems for auditing medicines management. The medicines audit completed in March 2023 showed medicine records had been reviewed and actions required for the issues identified, however, there were no people receiving medicines from staff; the audit was fictitious. The provider's failure to have a system which accurately reflected the management of medicines within the service placed people at risks associated with inaccurate records.
- The provider failed to keep accurate records of people's daily care, rotas, staff employment information, induction, supervision and training records. The provider failed to register their company with the Information Commissioner's Office (ICO) which is a requirement under the Data Protection Act 2018. We brought this to the attention of the provider who was unable to provide evidence at the time or after the inspection that they were registered with the ICO. This placed people at risk of a breach of their private

information.

The provider failed to assess, monitor and improve or mitigate known risks affecting the quality and safety of the service and failed to maintain accurate and complete records of people's care. This placed people at risk of harm. This is a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 did not fully understand their legal responsibilities. They failed to notify CQC about significant events which they are required to tell us. We brought this to the attention of the provider at inspection; they submitted a notification about the employment of staff. However, they failed to notify CQC of safeguarding concerns.

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

- People and their relatives shared their views and experience of the service at regular reviews. However, the provider had not been thorough enough to ensure all the changes to people's risk assessments and care plans included all their known health conditions or known risks.
- We saw no evidence of the service working in partnership with other professionals and agencies.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received care that met their needs and reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to treat people with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to have assessed all the risks to the health and safety of people or doing all that is reasonably practicable to mitigate any such risks. This placed people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to have sufficient systems in place to protect people from abuse and improper treatment. This placed people at risk of harm.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve or mitigate known risks affecting the quality and safety of the service and failed to maintain accurate and complete records of people's care. This placed people at risk of harm.

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant with Regulation 17 by 26 June 2023

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to follow safe recruitment practices which placed people at risk of receiving care from staff who have not been proven to be of good character. This placed people at risk of harm.

The enforcement action we took:

We issued a Warning Notice requiring the provider to be compliant with Regulation 19 by 24 April 2023.