All Seasons Community Support CIC

All Seasons Community Support Two Limited

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
All Seasons Community Support Two Limited is a domiciliary care agency. It provides personal care to adults living in their own houses and flats in the community. The service also provides support to two extra care housing blocks where people live in their own flats but have access to 24 hour care support from All Seasons care staff. Most people using the service were older people. At the time of the inspection the agency was supporting 338 people, of whom 325 were receiving personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
There were quality monitoring systems in place and these had identified communication, with and from the office, as an area for improvement. Actions taken to address this had not been sufficiently effective. People told us they were still experiencing difficulties in contacting the office "I have to pick my times of trying to get through". A staff member told us, "If you think a call is too late for a client and call the office like I did once to get told by someone in that office well if they don't like it leave." People also said they sometimes found responses to them by office staff, "grumpy, "sarcastic", or "unsympathetic".

The impact of the pandemic has led to staffing recruitment and retention issues with a number of unfilled hours. A number of people spoke about the lateness of calls and the impact this had on their needs being met in a timely way bordering on neglect and placing them at risk of harm.

Learning from incidents, accidents and safeguarding was not always disseminated widely to all staff to ensure consistency in good practice.

There was a complaints system in place that showed formal complaints were investigated thoroughly. However, people told us that often their informal complaints and concerns made to office staff went unanswered "I've given up I go through my care manager now."

People universally told us they felt safe with staff and their privacy and dignity was respected. People spoke positively of carers kindness, professionalism and the quality of support they provided them with. "I couldn't be treated better if I were royalty." "It's a very good thing to have a nice carer every morning, otherwise I would be very lonely, it's a valuable service." Staff were trained to recognise, and report abuse and the service had been proactive in doing so where necessary.

Medicines were managed safely with some minor suggestions for improvement. We have made a recommendation about the management of some medicines. Staff were given appropriate induction and training to undertake their role and were recruited safely.

Enough personal protective equipment (PPE) was made available for staff who told us they wore and changed this for every call, they had received training and additional information about COVID-19 and understood the importance of being fully protected.

Staff survey information and staff spoken with at inspection indicated the majority of staff felt supported and valued. Staff found the management team approachable and spoke positively about some of the incentives they were given including an employee assistance programme.

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 Good (published 2nd May 2019).

Why we inspected
The inspection was prompted in part due to concerns received regarding poor practice/poor care delivery by staff and issues with privacy and dignity, medicine errors, inadequate staffing, missed and late calls and lack of staffing continuity.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective 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.

The provider had already taken some remedial actions to address the staffing shortages. These included reducing the number of new care packages taken on in order to be able to support existing clients. Tackling habitual sickness amongst staff. Client routes were also under review to see if these could be more effective and lessen the number of late calls.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

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.

We have identified breaches in relation to Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

All Seasons Community Support Two Limited

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
The inspection was undertaken 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. It also provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service currently has two managers 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.

We gave the service 24 hours' notice of the inspection. This was because we wanted to be sure the registered managers and staff were available to speak with us at the site visit.

Inspection activity started on 18 August 2021 and ended on 1 September 2021. We visited the office location on 18 August 2021.

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

During the inspection
We spoke with 20 people who used the service and six relatives about their experience of the care provided. We spoke with 14 members of staff including both registered managers and two office staff. We also spoke with five commissioning, purchasing and operational representatives from the local authority and received feedback from two representatives from health.

We reviewed a range of records. This included six peoples care records multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A range of records relating to the management of the service, staff training, complaints, staff and user surveys were reviewed.

Requires Improvement

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 Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks relating to people's support needs and health conditions were not always assessed, monitored or reduced effectively. The level of detail in risk assessments varied. Some people were at risk of choking. One person's risk assessment gave detailed guidance for staff if the person did started to choke, however another person's choking assessment gave little information on the action staff should take.

● One risk assessment stated that the person sometimes displayed distressed behaviours. The information in the risk assessment as guidance for staff stated, "Use common sense". It did not inform staff on how to support the person in the way that suited them best in these situations.

● There was no information in one of the care and support plans to guide care workers on how to provide safe catheter care whilst also reducing any risks of infection. Catheters are tubes used to drain a person's urine
into an external bag. They can be prone to blocking and there is a higher chance of urinary tract infections. People may be at risk of not being supported appropriately with their health conditions or receiving medical attention when needed.

● People were at risk of scalds and burns as staff lacked understanding on how to protect people when serving hot foods and drinks. People had suffered harm as a result.

● One person told us, "The calls are more than often late. I have my last call at 8pm and they often are not coming again until 10:30-11am.They then came for the lunch time call at 1:00pm. I am unable to move from bed unassisted which means I have been lying in bed for over 14 hours. I have developed a UTI in the past as I was not able to use the toilet and had to hang on. I have complained but nothing has changed. It is really not good enough."

There was some evidence that people had been harmed and systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff to make sure people received the care and support they needed in a timely way. Most people and their relatives told us that carers were often late for calls. They said they were seldom told that calls would be late, or sometimes cancelled. People and relatives said if they called the office to find out what had happened the calls went unanswered. "I have sometimes had to contact the office, but the phone just rings and rings. If you leave a message, they don't get back to you. "

● Some people told us that although calls were late they did have some continuity of staff, While most other

people spoken with said they did not have a consistent team of staff who knew them well. They said they did not know who was coming until they arrived. "I don't think much of them at the moment. They used to be regular and good. It's all gone to pieces. There is no continuity of staff. I have different carers all the time. They don't know me. They don't know how I like things done. Every time a new carer arrives, I have to start from scratch. I haven't had a shower for 3-4 weeks. I ask but they don't have the time"

● Staff told they were rushed and had difficulty getting to calls on time. One staff member said in a six hour shift they had been given 12 half hour calls to make. This allowed for no travel time and meant people did not always get the full half hour and could feel rushed. A service user told us, and a carer confirmed that on one weekend recently one staff member was given 17 calls to make in a six-hour shift.

● The registered managers told us they continued to try and recruit new staff but throughout the pandemic had made recruitment and retention harder. Existing staff were offered more hours to cover gaps and also asked to review their current contracts and whether they wanted to work more often.

The provider had failed to deploy enough staff to ensure people received the care and support that they needed when they needed it. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

● Safe recruitment and selection procedures were in place. Applicants were required to provide a full account of previous jobs they had done. References from past employers had been obtained as had disclosures from the Disclosure and Barring Service. These disclosures establish if an applicant has a relevant criminal conviction or has been included on a barring list due to professional misconduct.

Using medicines safely

● Some people were prescribed medicine to take on an as required basis (PRN). There was no PRN guidance in place to inform staff how people should be supported with taking this safely. However, staff were able to tell us how they gave people their PRN medicines safely.

We recommend that the provider seek guidance from a reliable source on the protocols for administering PRN medicines in the community.

● When errors were identified action was taken to prevent re-occurrence.

● Staff had training in medicines, and this was updated regularly. Staff competencies to administer were also routinely assessed by unannounced observations by supervisors. Care plans clearly described people's preferred way of taking their medication.

● People told us they were supported to take their medicines when they needed them.

Learning lessons when things go wrong

● The registered managers told us that all accidents and incidents were recorded, analysed and acted upon. Actions from findings highlighting the need to improve practice where needed was passed onto the staff concerned. In discussion with staff and a review of team meeting minutes it was clear this information was not widely disseminated to all staff to effect learning, improve practice and prevent future recurrences across the service. For example, not all the staff had been made aware about the risks to people from food and drinks being too hot so action could be taken to prevent reoccurrence.

Systems and processes to safeguard people from the risk of abuse

● People felt safe when they were receiving care and supported from staff. However, the unintentional impact of when calls were very late meant that people were left at risk of neglect, because their needs were not being met in a timely way.

● Systems and processes were in place to ensure people were safeguarded from avoidable harm. Staff

understood their responsibilities for keeping people safe and knew how to report any concerns they had. Staff acted on safeguarding concerns and referrals were made to the appropriate local authority safeguarding teams.

Preventing and controlling infection

● Management staff understood their responsibilities to protect staff and service users by operating a safe system of infection control and monitored that staff were adhering to this.

● Staff were trained to understand how to maintain good infection control practice. This had been enhanced with additional guidance around Covid 19.

● Staff told us they had access to good supplies of Personal Protective Equipment (PPE) which they wore when supporting people; they were able to describe how this was used during visits to support people.

● People using the service and relatives confirmed staff took appropriate precautions by using gloves, aprons and masks when undertaking personal care and during their visits generally.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Peoples assessed needs and preferences were not always being met. People were not receiving person centre care due to the impact of late calls and lack of consistency of a staff team who knew them well and how they preferred to have their care and support. People and their relatives told us they were involved in sharing important information about their needs and agreeing scheduled times for their care calls. However, they told us that preferred call times did not always happen being late, or contracted times no longer met their needs. This often resulted in them being in discomfort, and unable to live their lives as they wanted to. "I can be in bed for 14-15 hours."

There was a failure to ensure that care designed to meet the needs and preferences of service users was provided in a consistent and timely way. This is breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014)

● Peoples needs were assessed by care managers initially who referred them to the service. Senior staff at the service decided whether they could meet the needs and wishes of the person referred. A care plan was then developed with the person and or their relatives that captured their needs and preferences. Any discrepancies in information the service became aware of were referred to care management.
● Senior staff were in the process of reviewing and re-assessing people who used the service, to ensure all care and support needs had been identified and could be met.
● People and relatives told us they had access to their own or relatives care plan and had contributed to its development and annual update. "They have recently updated my care plan and they talk to me about the care and support that I need" and "My relatives care plan is quite comprehensive, and they do review it once a year. "

Supporting people to eat and drink enough to maintain a balanced diet
● Care plans made clear what support people needed to meet their dietary needs.
● Staff told us they always ensured people were left with drinks within reach and snacks were easily available.
● Staff understood to monitor those people most at risk and to raise any concerns with the office to alert the GP or dieticians where necessary

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support
● Staff understood how to monitor people's health needs, such as skin integrity, toileting needs they referred people appropriately to/or sought advice from health professionals to ensure people received support for these needs.
● Staff understood about the importance of promoting healthier lifestyles to people. One staff member described to us how they worked with someone who was diabetic and made bad food choices. They told us that they supported the person with making healthier choices, and helped them in choosing and eating more nutritious meals.

Staff support: induction, training, skills and experience
● All new staff received initial induction training to prepare them for their role. Staff competencies were assessed to ensure they had understood what they had learned. They shadowed experienced staff and their performance monitored before they were able to work unsupervised. "I had a good induction. I shadowed until I was confident to go it alone. I completed the care certificate.
● A training matrix showed that a wide range of training was available to staff to complete and they were monitored in the completion of modules. "Training is a lot better than it used to be."
● Systems were in place for the supervisions and appraisal of staff. Staff confirmed they had observations of their practice carried out on visits, supervisions in the office and an annual appraisal of their performance. Frequencies had suffered due to the Pandemic lockdown but were now slowly improving. "We have regular supervisions. Normally do spot checks and observations, to check we are doing things ok, but obviously due to Covid19 this has reduced"
● People and relatives told us "Staff know what they are doing. They are well trained. I have confidence in them and feel safe". "The girls support me to do as much as possible for myself. All the staff that come to me are lovely and respectful."

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 Act 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 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff demonstrated they understood the principles of the MCA, supporting people to make choices when people were unable to make their own decisions.
● People confirmed the staff always asked their consent before providing their care.
● The management were aware of people who were subject to court of protection authorisations.

Requires Improvement

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 Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

● A range of quality audits, staff, service user and stakeholder feedback raised awareness of shortfalls in some areas. However, actions taken to date by the provider had not proved sufficiently effective and did not fully reflect the impact on service users lives. Such as uncertainties around call times and the effect this had on people's individual lifestyle and well- being. One person told us that they were trying to re- train their body to make sure they could cope with late calls. Another person told us that by staff not arriving on time impacted on their working life.

● Audits did not evidence the difficulties people faced in trying to get through to the office to discuss their care. "Office don't listen. They don't answer the phone. I rang 22 times over two days, but no-one picked up. This is the most frustrating thing. I feel ignored." A staff member told us, "People have told me that sometimes when they ring the office the staff are rude and dismissive."

● Checks had not identified that some risks assessments lacked detail, clarity and guidance for staff. Or that guidance was not in place to inform staff when people needed 'when required medicines.'

●The management team did not have full oversight and scrutiny of how the service was working for the people using the service and whether it was effective. People and staff told us improvements were needed "No one seems to have proper oversight," and "The girls are running around like headless chickens, I don't think it's well organised, there seems to be a lot of crossing over between calls – waste of time."

● An effective system to ensure statutory notifications were submitted to CQC was in place.

● Monthly audits were completed on medicines records to make sure they had been given correctly but we found some had not been audited since January 2021.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, 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 service provided did not fully promote a person-centred, open and empowering culture.

● Most people and relatives contacted told us they were happy with their carers who they found to be respectful, kind and caring. "Genuinely they do what's necessary the carers are lovely and polite not met anyone who was not up to scratch." Some people were satisfied with all aspects of the service. Others expressed concerns about how the office dealt with their queries and thought this needed improving. "The carers are very good on the whole, the office lets them down."

● Whilst formal complaints were recorded, investigated and managed appropriately, people told us that

their informal concerns and complaints were not responded to. One person told us they had written complaints to the office on a few occasions when their call times had changed but had never received a response."

● People and their relatives told us because they had so many different staff visiting, they were unable to build relationships with staff who knew how to care for them in a way that suited them best. One person said, "It's embarrassing to have such intimate care delivered by so many different staff. Every time someone new comes I have to start right from the beginning to make sure they support me, how I like to be supported." People and their relatives told us they had raised concerns, but they did not feel listened to.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and staff were sent surveys to complete but whilst people who gave positive comments did get feedback others who gave honest feedback of what was wrong did not "I did a survey and was honest about my concerns, but nothing has changed. The management only think about the money not the care."

● The provider had been proactive in trying to involve staff in discussion and decision making at trustee level by enabling several staff representatives to sit on the board of trustees.

● The majority of staff spoken with despite some frustrations around communication demonstrated loyalty to the service. They felt well supported by the management team who they said were approachable. They felt they were kept well informed about changes that affected their work.

Continuous learning and improving care

● Accidents and incidents were analysed and any learning from these passed onto the staff concerned, but not always widely disseminated to all staff. A recent safeguarding in regard to scalding and burns had precipitated burns awareness training being arranged for staff. In the mean time staff not directly involved in the alert were unaware of any change in practice they needed to be aware of and this could continue to place people at risk.

● In spite of current staff resource issues, the management were trying to improve and provide more consistent and seamless care to people. Members of the management team worked closely with reablement teams, sat on the CCG GP panel where they could sometimes resolve issues quickly. They were working to establish a bespoke team to work with GP's and to establish an acute response team. They also worked with housing managers and were looking to work with Macmillan nurses and liaise with the CCG regarding providing a better quality of life for people who were at the end of their life.

The provider failed to ensure the systems in place to regularly assess and monitor the quality and safety of the service was effective. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● Local authority purchasers, contractors, commissioners and care managers acknowledged the service had faced an unprecedented and difficult time in meeting its contractual commitments and some people were not receiving their service in a timely manner. They felt there were missed opportunities for the service to take advantage of support they could offer to them and would like this to improve going forward.

● The management team have established good links with agencies who contract with them, and meet with them regularly.

● Health agencies who contract for short term care of their service users praised the support the service provided their service users and called them "responsive".

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 There was a failure to ensure that care designed to meet the needs and preferences of service users was provided in a consistent and timely way.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was some evidence that people had been harmed and systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the systems in place to regularly assess and monitor the quality and safety of the service was effective. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to deploy enough staff to ensure people received the care and support that they needed when they needed it.