Aliizor Ltd

Lizor Care Concept

Inspection report

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Date of inspection visit:
11 October 2022
20 October 2022

Date of publication:
04 January 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Lizor Care Concept is a domiciliary care agency providing personal care to people in their own home. At the time of our inspection there were 20 people using the service.

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
People's medicines were not always safely managed. This was because guidance for staff was not always clear. This meant people were at increased risk of experiencing harm from avoidable medicines errors.

The provider failed to ensure robust recruitment procedures were followed. This meant the provider could not be assured prospective staff always had the required skills and competence to support people safely. The provider told us they had enough staff to support existing care packages although this was not the experience of some people. Overall, people received their visits on time, however people told us they were supported by an inconsistent staff team.

Whilst some auditing had been developed, shortfalls in the service were not always being identified. This included areas such as the administration of people's medicines and care planning documentation. For example, the electronic monitoring system highlighted if staff had not arrived to support a person, so action could be taken. However, an analysis of such concerns had not been considered. This did not give an overall picture of the frequency or circumstances of these situations, and therefore any action required as a result.

Systems were in place to help protect people from the risk of abuse. However, an incident had recently occurred, which placed a person at risk of significant harm. The provider apologised for this and assisted the local safeguarding team with their investigation as required.

Focus had been given to the assessment and management of risk, which enhanced safety. Staff had received training and knew how to safely use equipment people had in their own homes. People and their relatives confirmed staff's confidence and competence in this area. The provider had a willingness to learn, and showed they would address shortfalls once brought to their attention.

People told us they felt safe and were satisfied with the support they received. They said positive relationships had been established with some of the staff and their rights were promoted. People told us the service was reliable and they had their care regularly reviewed. They were encouraged to give their views and told us management were always available and addressed any concerns they might have.

Staff felt supported, and were able to gain advice at any time. They had received training to help equip them to undertake their role effectively. This included topics such as dignity, communication and equality and diversity, which promoted a positive culture.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 27 May 2022) and there were breaches in regulation. We issued a Warning Notice in relation to good governance.

In June 2022 we completed a targeted inspection to check whether the Warning Notice had been met. We found improvements had been made and the Warning Notice had been met.

At this inspection we found the provider remained in breach of regulations.

The last rating for this service was requires improvement (published 27 May 2022). The service was also rated requires improvement at the inspection in March 2021. The service remains rated requires improvement. This service has therefore been rated requires improvement at three out of four inspections.

Why we inspected
We received concerns in relation to a person's safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

Once aware of the concerns, the provider apologised, took appropriate action and worked with the local safeguarding team.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lizor Care Concept on our website at www.cqc.org.uk.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Lizor Care Concept

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 undertaken by one inspector, one assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 11 October 2022 and ended on 21 November 2022. We visited the office on 11 October and 20 October 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with three people who use the service, seven relatives, seven staff including the registered manager and provider and a health and social care professional. We looked at people's medicine records, assessments of risk and information related to the management of the service.

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 our last two comprehensive inspections, we rated this key question requires improvement. At this inspection the rating has remained 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.

Using medicines safely
At our last comprehensive inspection, the provider had failed to keep an accurate record of the medicines they had supported people to take or to have effective systems to assess, monitor and improve the quality of the service provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found enough improvement had been made in relation to the accurate recording of people's medicines and the provider was no longer in breach of this part of regulation 17. However, at this inspection, shortfalls in the recording and documentation of medicines were identified. While no one was harmed, there was a risk that people may not receive their medicines safely.

- The medicine administration records (MAR) did not always show clear instructions about the medicine's prescription. This was because some of the information was inconsistent or conflicting. For example, one instruction was 'two in the morning', but the dosage of the medicine was one tablet. This increased the risk of a medicine's error. We highlighted this issue during the inspection, and the provider has confirmed that this has been rectified.
- One person was prescribed tablet and liquid paracetamol, but they were not identified separately on the MAR. This did not ensure an accurate record of the medicine administered. The provider told us the person did not always want the full dose of the liquid medicine so a lesser amount was sometimes given. Staff had not documented the amounts they had administered on the MAR.
- The information showed there were occasions when the organisation of people's visits did not take into account time specific medicines. This meant some time specific medicines had been given too close together, which increased the risk of the person being overdosed.
- Daily records showed some people had topical creams applied. However, these creams had not been identified on the MAR. Some records showed staff where the topical creams were to be applied and how often, but this was not the case for all records.
- Daily checks of people's medicines had been introduced, but these were not always used effectively to identify and rectify shortfalls, such as those outlined above. After the inspection, the provider told us they had undergone additional training in respect of its systems and is committed to improving in this regard.

Systems had not been effectively established to ensure the safe administration of people's medicines. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records showed, and staff told us they had received training in the safe administration of medicines, and had their competency assessed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last comprehensive inspection, the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Focus had been given to risk management and improvements had been made to enhance safety.
● The risks people faced had been assessed. These included areas such as moving people safely, the use of oxygen, nutrition, dehydration and skin integrity.
● The assessments were up to date, showed the level of risk determined and any action required to mitigate the risks identified.
● Staff who supported people regularly, knew how to use the equipment that was in place to aid mobility. One relative told us, "They transfer [person] with the hoist. They handle it very well. They're methodical and precise." Another relative said, "They use the [type of hoist] very well. They take great care lining it up and applying the belt, making sure it's all secure. I've never had any issues."
● People and their relatives told us they received a reliable service which enhanced safety. One relative said, "95% of the time, they come on time. On the odd occasion that they're delayed, maybe due to a traffic hold up, it might be by 10-15 minutes". Another relative said, "They're usually on time, if they're a bit late, it's by 5-10 minutes. I've no complaints about punctuality."
● Whilst people and their relatives told us they had no concerns about safety, three accidents were described. One relative told us the staff member did not put the shower mat in the bath correctly, causing their family member to fall. They said they informed the provider of this, who was very apologetic. Another relative told us their family member had a skin tear, which was possibly caused when the sling of the hoist was removed from underneath them. They said the staff were very upset and apologised.
● The provider and registered manager told us they were committed to learning from any identified shortfalls. The provider said this included CQC inspections, which helped them learn and further improve.

Systems and processes to safeguard people from the risk of abuse
● Systems were in place to minimise the risk of people experiencing abuse. However, an incident recently occurred which placed a person at significant risk of harm.
● Appropriate action was taken regarding the member of staff, once the provider was fully aware of the incident. The provider apologised for the incident and said they would co-operate fully with the local safeguarding team.
● To minimise a similar incident, the provider told us they would be talking to all staff and ensuring each one undertook a refresher training course in Code of Conduct.
● Records showed, and staff told us they had received training in safeguarding vulnerable people.

We recommend the provider revisits the safeguarding training staff receive, and ensures staff are confident and competent to apply their learning in their practice.

● People told us they felt safe whilst being supported by staff. One person said, "I'm very pleased with my

care, I feel safe with them. I'm quite ok and I haven't had any problems with any of the staff." A relative told us, "I haven't got any concerns at all. They have all treated [family member] very well."

Staffing and recruitment

● Staff were not always recruited safely.

● Job applications did not always provide a comprehensive work history from leaving school. There was not a written explanation for any gaps in employment or evidence of conduct in previous jobs with children and/or vulnerable adults. The impact of the agency being the applicant's second job had not been discussed. Whilst information had been sought about the applicant's performance, there was not an audit trail to show how this had been requested. After the inspection, the provider told us they had reviewed all applications and a robust recruitment procedure was now in place.

Records did not show recruitment processes were sufficiently robust to ensure staff recruited had the qualifications, competence, skills and experience which were necessary for the work to be performed. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives gave variable feedback about whether there were enough staff. One person told us they did not want a male member of staff supporting them with their personal care, although in the evening this could not be accommodated. This meant a relative had to assist them at this time. After the inspection, the provider told us they made a conscious effort to accommodate people's requests of being supported by a male or female staff member. They said they would give advance warning on the rare occasion that a male member of staff was required for support so that a relative could assist with personal care if needed. Other comments were, "We usually have regular staff. The way we got around it, was to bring our morning call forward to 8.30 am. We found that with the original time of 9.45am, we got a certain type of carer and they were rarely regular ones" and, "We get a mixture of staff. They are short staffed and we seem to get anyone who is available."

● The registered manager told us recruitment was ongoing, with a particular focus on care staff who were able to drive. They said they had reached capacity and until more staff were recruited, no more care packages would be accepted. A management meeting had raised that quality should be the key in recruiting, not quantity.

Preventing and controlling infection

● Systems were in place to ensure the prevention and control of infection.

● People and their relatives told us staff always had clean uniforms and wore their personal protective equipment (PPE) appropriately. One relative said, "They're very diligent with their PPE, changing their gloves for different parts of the operation and cleaning their hands." Two relatives however, told us staff would often lower their masks to enable their family member to hear them when talking. After the inspection, the provider told us one of these people relied on lip reading for their communication. They said the service ensured appropriate mitigation factors were followed such as maintaining a safe distance when removing any PPE, in line with government COVID-19 guidance.

● The provider and staff told us there were ample supplies of PPE, which could be easily accessed.

● There was an up to date infection prevention and control policy, and staff had undertaken infection prevention and control training. This included an additional Covid-19 training.

● Spot checks of staff's performance were undertaken to ensure staff were following safe practice, when supporting people.

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 our last two comprehensive inspections, we rated this key question requires improvement. At this inspection the rating has remained 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; Continuous learning and improving care

At our last inspection, systems were either not in place or robust enough to assess, monitor and improve the quality and safety of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Whilst some improvements had been made to the auditing systems, not all shortfalls were being identified or sufficiently addressed. This did not ensure ongoing development and safety of the service. As a result, the service has not ever reached the attributes of a good rating overall.
● Checks had identified staff had not always signed the MAR to show they had administered people's medicines. The reasons for this were explained as technical issues. There were no further investigations to confirm this, or any analysis to show the extent of the problem.
● The provider had not audited the staff personnel files, or the processes being used to recruit new staff. This meant shortfalls, including gaps in an applicant's work history and a clear audit trail of information, had not been identified. This did not ensure staff were being recruited safely, which increased the risk of potential harm. After the inspection, the provider told us they had overhauled their recruitment systems and were conducting a full audit of staff personnel files.
● The electronic monitoring system produced alerts if staff had not arrived to support a person or care interventions had not been completed. The provider told us they would immediately call staff to ensure there were no problems, and there was an offline system to mitigation any shortfalls with effective recording. However, an investigation into the signalling difficulties experienced and the impact this had on effective recording and safety, had not been undertaken.
● The auditing systems had not identified some information within people's care plans was not up to date or person centred. For example, people's health conditions and generic symptoms were stated, but guidance about the impact on the person was limited. Some information, including in relation to one person's confusion, was not detailed in their care plan. This did not ensure staff were fully aware of the best way to support people.
● The provider told us they wished to continually improve the service, and used inspections as a way of

doing this. They said any shortfalls identified would be addressed, and a means to learn and improve the service. However, a more effective auditing system was required to ensure consistent quality and safety of the service.

Systems had not been established to assess, monitor and improve the quality and safety of the service. This placed people at increased risk of harm. This was a repeated breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The electronic monitoring system highlighted if staff training was about to expire, or if a care review was required. The registered manager told us the system would not allocate any work to a staff member if they had not completed their training.
● The provider and registered manager undertook spot checks of staff to monitor their performance. People and their relatives spoke of the spot checks which were undertaken. One relative told us, "The managers and assessors come regularly and do a review of the care staff and their practice. For example, they might look at how they're doing catheter care."

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
● There had been occasions whereby staff had not been open and honest when reporting an incident. This questioned their own integrity, but also the overall culture of the agency. The provider informed us staff had completed their training, so knew how to perform and conduct themselves. They said the incidents had fallen short of their expectations and apologies had been given.
● There was an on-call system which operated outside of office hours. Staff told us this worked well, as they were given good advice and felt well supported. People and their relatives confirmed the on-call system was effective. One relative said, "The new management structure is much better, and they're always at the end of the line, if you need to contact them, or talk to someone."
● There were various online training courses, such as equality and diversity, dignity and communication which staff were expected to complete. This helped facilitate a positive, empowering culture.
● People and their relatives were generally of the view the service was well run. One person told us, "They do seem to run everything pretty smoothly and do a good job." Another person said, "If I communicate with them about anything, they do act on it. It's quite well run, pretty efficient on the whole."
● A health and social care professional told us they had received good feedback about the agency. They said the care package for the person they had been involved in, had been set up and managed well without any concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People and their relatives told us they were given regular opportunities to share their views about their support. However, the information had not been coordinated to give an overview of the service. The provider told us any concerns would be individually addressed with those involved and recorded on their file. This did not enable the provider to identify potential themes and trends so they could act accordingly.
● Feedback was gained through the use of surveys, telephone calls and care reviews. One relative told us, "The manager gives me a ring regularly and checks that everything is okay."
● People, their relatives and staff were encouraged to raise a concern if they were unhappy with the service. One relative told us they made a complaint about the staff not being able to communicate with their family member in English. They told us, "I put it in writing and from that point on, it immediately changed."
● Staff told us the provider and registered manager listened to what they had to say. They said if they had

any concerns, they were encouraged to raise them with the management team. They were confident all would be satisfactorily resolved.

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 17 HSCA RA Regulations 2014 Good governance Systems had not been effectively established to ensure the safe administration of people's medicines Regulation 17(2)(c) Systems had not been established to assess, monitor and improve the quality and safety of the service. Regulation 17(2)(a)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Records did not show recruitment processes were sufficiently robust to ensure staff recruited had the qualifications, competence, skills and experience which were necessary for the work to be performed. Regulation 19(1)(b)(2).