

Acute Need CIC

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Inspection report

161 College Street
St Helens
Merseyside
WA10 1TY

Tel: 01744881525

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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 caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

Acute Need CIC is a domiciliary care agency providing personal care for people living in their own homes. The service provides care and support to people who have an acquired brain injury and or a physical disability. At the time of our inspection there were 13 people using the service across the North West of England.

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

The provider was operating parts of this service outside of the regulatory framework. The provider had not applied to be registered with the CQC for all the regulated activities taking place. The CQC assesses the suitability of applicants to safely provide the relevant regulated activity upon application, this had not taken place. The legal responsibility to ensure the service is appropriately registered rests with the provider and the registered manager.

We were not assured the registered manager and provider had appropriate governance arrangements in place, to assess, monitor and ensure safe clinical practice. We raised two safeguarding alerts with one local authority regarding this.

The systems in place did not always ensure as much as possible that people were safeguard from the risk of abuse. Staff recruitment systems were not robust and the providers oversight of the safety of clinical tasks was not effective.

The service had pockets of differing approaches, style and cultures within the teams built around people. In some areas they were thoughtful, inclusive and empowering. However, there was also areas of disempowering and demeaning practices at times. The provider had not ensured there was a consistently positive and empowering culture across all aspects of people's support.

The provider had not consistency followed the principles of the Mental Capacity Act. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the practices taking place at the service did not uphold people's rights in accordance with the Mental capacity Act 2005.

On multiple occasions we had to ask for information in order to complete our inspection. At times information that was given to the CQC was not clear, straightforward or was presented in an ambiguous manner.

Feedback from people's family members was mostly positive. Some people's family members told us about person centred care that their relatives had received which had supported them to achieve good outcomes. One person's relative told us, "The service is excellent, I can't fault it."

There were systems in place to help ensure people received their medication safely. People and their family members told us they were well supported by Acute Need CIC during the COVID-19 pandemic.

People were supported to access healthcare services and to be as healthy as possible. Staff had been proactive when supporting people to access healthcare services.

It was evident that care staff cared about and had warm and positive relationships with people. We also saw that the provider and registered manager had warm relationships with people.

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 outstanding (published 10 January 2019).

Why we inspected

The inspection was prompted in part due to safeguarding concerns shared by a local authority. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from outstanding to requires improvement based on the findings of this inspection.

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

Enforcement and Recommendations

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 monitor the service and will take further action if needed.

At this inspection, we have identified breaches in relation to protecting people's rights under the Mental Capacity Act 2005 and keeping records of decisions made on behalf of people; ensuring that safe recruitment practices were in place for new staff; ensuring the system for providing and monitoring staff training was effective; and failing to ensure there was an effective system in place to assess the safety, quality and regulatory compliance of the service.

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 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 always safe.

Details are in our safe findings below.

Requires Improvement



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



Acute Need CIC

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

This inspection was carried out by one inspector.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was announced. We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 11 March 2022 and ended on 27 May 2022. We visited the location's office on 11 March 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from one 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 visited the office location used by the provider.

Following this, we spoke with two people who used the service and we visited or spoke by telephone with four people's relatives. We spoke with the nominated individual; the nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the registered manager and we also spoke with six members of staff including nursing and care staff. We spoke with six health and social care professionals.

We reviewed a series of documentation, including care records and records relating to the management and oversight of the service by electronic file sharing following our visit to the office. We also had a series of video conference calls with the nominated individual and the registered manager.

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 inspection we rated this key question outstanding. At this inspection the rating has changed 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; learning lessons when things go wrong

- Each person had individualised risk assessments in place. These had been reviewed monthly by a senior member of staff.
- Some risk assessments were detailed and provided appropriate information for staff to help reduce the risk. Other risk assessments did not contain all the appropriate and relevant details that would enable staff to be aware of the risk that may present itself. For example, specific health risks and details of what a person may do that would pose a risk to themselves or others.
- The systems in place for reviewing and learning lessons when things go wrong were not always used effectively. At times there was a disconnect between staff responsible for reviewing risk assessments and the staff teams providing care and support to people. The provider did not have an effective system for gathering and reviewing information that would enable them to assess, monitor and have oversight of risk. For example, incident records were not always reviewed when monitoring risk, this meant that the risk assessment did not always accurately reflect the care being provided to reduce risks.

Systems and processes to safeguard people from the risk of abuse

- The systems and processes did not always ensure as much as possible that people were safeguard from the risk of abuse.
- Staff fitness and suitability for their role was not always checked, and the provider lacked oversight of the safety of clinical tasks carried out by nurses, placing people at risk of abuse.

The provider failed to ensure appropriate systems were in place for the ongoing monitoring of risk. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us that they felt safe with the staff members supporting them. People's family members told us they were confident that staff kept people safe from the risk of abuse.
- Staff were knowledgeable about safeguarding people from the risk of abuse.

Staffing and recruitment

- Safe recruitment processes were not always followed.
- There were some recruitment checks in place for new staff members. However, recruitment records lacked evidence of the required checks being carried out on staff before they were employed. For example, there was limited information about people's work history and a lack of satisfactory evidence of their conduct in previous employment within social care. There was no evidence that people's identification had been

checked.

The provider had failed to ensure that robust safe recruitment practices were in place at the service. This is a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staffing levels for each person was assessed to make sure they received the right care and support to safely meet their needs. People received care and support from the right number of staff.
- People and their family members told us that the service was reliable and always provided the needed staff members from within the organisation.

Using medicines safely

- There were systems in place to help ensure people received their medication safely.
- People's family members praised the safe use of medication. One person's family member told us how a diligent staff member was able to spot a dispensing error and prevented the person from receiving the wrong dose of medication. Staff received training in medication administration.
- People had been supported by care staff in partnership with medical professionals to reduce some of their medication when appropriate to do so.

Preventing and controlling infection

- People and their family members told us they were well supported by Acute Need CIC during the COVID-19 pandemic. One person's family member said, "Acute Need coped with it really well. They protected [Name] as much as they could."
- People had been supported to participate in the COVID-19 vaccination programme.
- People who had been assessed as clinically vulnerable to COVID-19 had a set team or 'bubble' of staff set up around them to help reduce the spread of any virus.
- The provider had put extensive effort into ensuring that staff members always had access to appropriate PPE throughout the COVID-19 pandemic.
- We were assured that the provider had been accessing testing for people using the service and staff.

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 our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 provider had not consistently followed the principles of the Mental Capacity Act 2005.
- Some people's care plans, and daily care notes contained details of restrictions placed upon them by care staff. These care plans had been put together by senior staff who were unaware if the legal authorisations for these restrictions were in place. They had not followed the legal protections in place to uphold people's rights.
- When making significant decisions on a person's behalf the provider had not always ensured they had followed the best interest decision making processes. This meant that at times, decisions had been made on people's behalf without ensuring they received the protection of the legal safeguards and processes in place. There was no record of people's opinions and voice being listened to and taken into account in these particular decisions.
- The provider did not demonstrate they had consistently supported people to make as many informed decisions for themselves as possible.

This is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured they had protected people's rights under the Mental Capacity Act 2005.

Staff support: induction, training, skills and experience

- The provider did not have an effective system in place to ensure that staff members had the skills and competencies required to safely provide the care and support people needed.
- The support of nursing staff was ad hoc, confused and was not appropriately structured. It was unclear who had oversight of the practice of nursing staff at Acute Need CIC. Nursing staff had responsibility to train care staff to perform clinical tasks that were delegated to them under their oversight. We asked the provider on a number of occasions for details of the structure of the organisation and staff line management responsibilities; we never received this. Different nursing staff described a different structure.
- Staff members told us they felt supported to be effective in their roles. However, there was little evidence of a structured and effective system in place to provide staff support.

This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the system for providing and monitoring staff training and support was effective.

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

- People were supported to have a healthy and balanced diet.
- The support provided was tailored to each person's needs. Some people needed specialised support with their nutritional intake and other people needed support to help them with choices.
- People were supported and encouraged to get involved in the shopping for and preparation of their own meals.

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

- Feedback and information obtained during our inspection regarding the assessing of people's care and support needs was mixed.
- Some people and their family members told us they were happy with the initial assessment of their needs. They described the assessment as being thorough and effective. Other people's care planning showed the assessment of their needs had not been effective.

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

- The feedback regarding being able to work effectively with Acute Need CIC from outside agencies was mixed.
- Health and social care professionals described staff at Acute Need CIC as being effective and creative in partnership working and problem solving. Other health and social care professionals told us that they had difficulty in obtaining relevant information.

Supporting people to live healthier lives, access healthcare services and support

- People were supported to access healthcare services and to be as healthy as possible. Staff had been proactive when supporting people to access healthcare services.
- Staff supported people to arrange and attend medical appointments. They were also supported with hospital visits, and if needed during any hospital admission; to help ensure that people's support and communication needs were met when they accessed healthcare services.

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.

At our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

- People had not been consistently supported to express their views and be involved in decisions.
- Mostly people were involved in and were supported to make decisions for themselves in day to day matters. One person told us, "The staff listen to me all the time." However, we did not find this approach to be consistent across different areas of people's support. At times people had not been effectively supported to express their views and make decisions and choices regarding more significant matters.
- Feedback from health and social care professionals about people being supported to express their views was mostly positive. One health professional told us, "They get people very involved from the outset, for example with the recruitment of their own staff team." Another told us, "This is the first time [Name] has their voice and what they want."

Respecting and promoting people's privacy, dignity and independence

- People's dignity was not always upheld, and they were not always referred to in a respectful manner. At times people's care plans, risk assessments and daily care records did not refer to people in a respectful and dignified manner.
- The personal interactions between staff and people supported were respectful, thoughtful and dignified. People told us that support staff treated them well; one person told us, "Staff treat my home well and look after it." People's family members also described the service they received as being very respectful of their homes and privacy.
- The provider had taken steps to support some people to increase their independence in a number of areas. One health and social care professional told us, "They have been excellent in the promotion of independence and autonomy with [Name], I could not have asked for more and they obviously care for [Name] very much."

Ensuring people are well treated and supported; respecting equality and diversity

- It was evident that care staff cared about and had warm and positive relationships with people. We also saw that the provider and registered manager had warm relationships with people.
- People and their family members told us that they were well treated by support staff. One person told us, "I like my care staff. I enjoy doing things with them and being out and about." One person's family member told us, "They are always respectful; this really helps our relationship. We have never had a relationship problem."
- At times people's opinions were sought with regards to their preferences about the approach and terms used by care staff. For example, one person had been consulted on the phrase's used in their care plans,

records, how staff members were referred to and the language used when having conversations with staff members.

Is the service responsive?

Our findings

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

At our last inspection we rated this key question outstanding. At this inspection the rating has changed to 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

- Care planning was not always responsive to people's needs and preferences.
- At times information that was fundamental and key to the provision of people's care meeting their needs and preferences was missing. For example, information about people's capacity to make decisions and how this impacted their day to day care and support.
- Care planning had not ensured that people had maximum choice and control within their lives and had not planned how people would be supported to make decisions. Some significant decisions that had been made in people's care and support had not been recorded. For example, decisions regarding people's accommodation.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that care planning was always effective in keeping a record of the decisions taken in relation to the care and treatment provided for people.

- Some health and social care professionals told us about examples of responsive care planning. One health care professional told us about the provider, "They are very forward thinking and are great with ideas and [making] suggestions."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to maintain relationships and to spend time with their family and friends.
- Staff supported people to be active members of their community and to do things that they enjoy and were meaningful to them. Staff supported people to pursue their interests, to remain in contact with people and to make new connections and form new relationships.
- People's family members described to us how the design of people's care and support positively promoted them maintaining their relationships and helped remove barriers to ordinary living.

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 had an individualised communication care plan to help provide staff with information on how people communicated. Communication plans enabled staff to help ensure that people were communicated with in a manner they understood and is meaningful to them.

Improving care quality in response to complaints or concerns

- People's family members told us that the provider was responsive to any concerns they raised, and they had confidence in the process and them being resolved.

End of life care and support

- Nobody was receiving end of life care at the time of our inspection.

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 inspection we rated this key question outstanding. At this inspection the rating has changed to 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care

- The provider was operating parts of this service outside of the regulatory framework. The provider had employed registered nurses to provide the regulated activity of Treatment for Disease Disorder or Injury (TDDI). The provider had not applied to be registered with the CQC for this regulated activity. The CQC assesses the suitability of applicants to safely provide TDDI upon application, this had not taken place. The legal responsibility to ensure the service is appropriately registered rests with the provider and the registered manager.
- We were not assured that some people were receiving safe treatment. Some people who received the regulated activity of TDDI had this provided by care staff under the oversight of registered nurses employed by the provider. However, we were not assured the registered manager and provider had appropriate governance arrangements in place, to assess, monitor and ensure safe clinical practice. We raised two safeguarding alerts with one local authority regarding this.
- The provider built individualised teams of nursing and care staff for each person. These teams operated over a wide geographical area. We asked several times during our inspection for details of the company structure and how the provider assessed and monitored the ongoing safety and quality of the services being provided. The information provided was limited and did not demonstrate clear lines of responsibility and accountability. In view of this and the concerns highlighted during our inspection, we were not assured that the governance arrangements the provider had in place were adequate in assessing the quality and safety of the service.
- Improving and learning from people's care had not always been consistent and effective. At times information had not been shared and used to support the practice of continuous learning and improvement. Learning from incidents when staff intervened to reduce risks was not used to improve People's care.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to have an effective system in place to assess, monitor and improve the quality, safety and regulatory compliance of the service.

We have shared our concerns with the relevant service commissioners.

- Health and social work professionals told us of times when the provider and registered manager had put in place practical and creative solutions, demonstrating responsiveness and learning from events that had

not worked out previously in a person's life.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The organisation had pockets of differing approaches, style and cultures within the teams built around people. In some areas they were thoughtful, inclusive and empowering. However, there was also areas of disempowering and demeaning practices at times. The provider had not ensured there was a consistently positive and empowering culture across all aspects of people's support.
- Some people told us that they were not always supported to make informed decisions and at times people were not supported to be aware of and assess options that were available to them. There was a culture within the provider of doing what they thought was best for people, or at times only involving people in the later stages of decision making. The provider had not ensured that the principles of the Mental Capacity Act 2005 were applied when providing care and support for people.
- Some people's family members told us about person centred care that their relatives had received which had supported them to achieve good outcomes. One person's relative told us, "The service is excellent, I can't fault it."
- People supported, and their family members told us that the provider and registered manager engaged and communicated effectively with them. One person described the positive relationship they had with the provider. People's family members described positive engagement; one told us, "Communication is good, the balance is just right. Everything runs like clockwork." Another person's family member told us, "We can phone anytime; the communication is good. The last couple of years have been the smoothest we have had."

Working in partnership with others

- The feedback received from health and social care professionals was mixed. Some professionals told us that communication has been "open and honest". However, others told us that information sharing and working in partnership with the provider was difficult.
- On multiple occasions we had to ask for information in order to complete our inspection. At times information that was given to the CQC was not clear, straightforward or was presented in an ambiguous manner.
- People's family members told us that the provider had effectively worked in partnership with them. One person's family member told us that partnership working was effective and told us, "Cooperating is really important for [Name] and their family."

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

- When the provider had been made aware that something had gone wrong, they had taken action and shared information appropriately.
- The provider had not always ensured they had informed the CQC of all events that they were legally obligated to do so.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured they had protected people's rights under the Mental Capacity Act 2005.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure appropriate systems were in place for the ongoing monitoring of risk. The provider had not ensured that care planning was always effective in keeping a record of the decisions taken in relation to the care and treatment provided for people. The provider had failed to have an effective system in place to assess the quality, safety and regulatory compliance of the service.
Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that robust safe recruitment practices were in place at the service.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure the system for providing and monitoring staff training and support was effective.