Leader Care Ltd

Leader Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Leader Care is a domiciliary service providing personal care to 41 people.

People's experience of using the service
Risk assessments were not always completed or robust. We found assessments had not been completed when there was documentation to suggest a risk was present. Medicines were not managed safely as poor documentation meant we were unable to determine if all medicines had been given. We also found medication stock counts were incorrect.

Staffing levels were sufficient however, visits were often missed or late. Recruitment procedures were not effective as some staff had started working prior to relevant checks being carried out. The provider had not always investigated or taken action from safeguarding incidents and concerns related to risk, to protect people who used the service from harm.

Staff were not provided with the relevant training to meet peoples specific care needs. The induction procedure did not include any face to face training and induction books had not always been completed prior to staff starting work. Staff were not provided with regular supervisions or spot checks to check their competencies.

The provider failed to assess, monitor and improve the quality of the service and maintain accurate and robust care records. We found shortfalls in recordings; for example, Medication Administration Records (MARs), care plans and risk assessments were not always signed, updated or completed.

Audits had not been carried out on a regular basis to ensure oversight and monitoring of the service. There was no evidence of analysing trends or themes within the service to prevent against possible risks and improve care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in the service did not support this practice. We have made a recommendation about the Mental Capacity Act within the report.

Care plans were in place but not always updated to reflect peoples' current needs and related risks. People and their relatives were involved in their care planning. End of life care plans were in place, but they did not always identify people's preferences and choices.

Complaints were recorded however, the actions recorded as taken had not always been completed.

People and their relatives told us the staff were caring and polite. People's dignity had not always been respected. People and their relatives told us communication with the office was poor.

Staff were aware of infection control practices in relation to the latest COVID-19 government guidance for the use of Personal Protective Equipment (PPE) to keep people and staff safe. However, staff told us they had not received any specific training in relation to PPE during the COVID pandemic.

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

Rating at last inspection
This service was registered with us on 07/06/2019 and this is the first inspection.

Why we inspected
This was a planned inspection. The inspection was prompted in part due to concerns received about overall care quality and safeguarding concerns.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively
You can see what action we have asked the provider to take at the end of this full report.

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 five breaches in relation to safe care and treatment, staffing, safeguarding, fit and proper persons and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Leader Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector, a specialist advisor 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
Leader care is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager however, they had not yet 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.

Notice of inspection
We gave 24 hours' notice of the inspection. Due to the COVID-19 pandemic we wanted to review documentation remotely and also make arrangements to speak with people, relatives and staff by telephone after our site visit. This helped minimise the time we spent in face to face contact with the manager, staff and people who used the service.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service including Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

During the inspection
We spoke with four people about their experience of the care provided and five relatives. We spoke with the nominated individual, regional manager, the manager and four staff members. We looked at six people's care records and five medicine records. We looked at staff files for recruitment, supervisions and training records. We also looked at quality monitoring records relating to the management of the service such as audits and quality assurance reports.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

• Risks were not managed effectively and information in risk assessments lacked detail. For example, two people had bed rails in place however, there was no risk assessment with guidance for staff on how this risk should be managed.

• One person required a soft diet however; the risk assessment did not provide a reason as to why the person needed a soft diet. There was no record of a choking risk assessment or what foods staff should be providing in relation to their specific diet. The person had been referred to speech and language therapy but there was no information as to whether the person had an assessment carried out. The manager said they did not provide the person with their nutritional needs however, this was not noted in the file and staff still needed to be aware of the persons risks ensuring their safety.

• Fall risk assessments were not robust. One person was at risk of falls and the risk assessment did not document the measures in place to mitigate this risk.

• Moving and handling training was not sufficient. One staff member had not renewed their training, and another said, the online training provided to staff did not demonstrate what techniques should be used to safely move people.

• Training had not been completed for staff who cared for people at risk from specific health conditions such as diabetes, stoma and catheter care. Staff said they supported people with these complex needs. One person said, "I've got a catheter in, they [staff] forget to turn it off so sometimes it's still leaking and I get a wet leg." One staff member told us they had observed staff changing a person's dressing for a pressure sore without having formal training. We discussed this with the provider who said they would investigate and improve their training procedures.

• Visiting times were often not when they should have been, and people were left waiting for their visits. One person said, "At first they were arriving at 10 in the morning that meant I had to take medication later in the night."

Using medicines safely

• Medicines were not managed safely. Medication administration records (MARs) were inaccurate and put people at possible risk. One relative told us, "Twice they [staff] went to leave and had not given the medication. It is a major issue, whoever is coming should be giving them as the tablets are giving [name] life."

• Staff had not always recorded when medicines had been administered. We found examples where staff had not signed MARs to confirm medicines had been given.

• Stock counts were not accurate. For example, one person's medication stated 10 tablets were in stock on the 12th of the month however, on the 16th only four were left in stock. One tablet per day should be administered therefore, six tablets should have been left.

• Medication audits lacked detail for example, stock checks were not included in the audits to ensure investigations were carried out from any errors.
• Medication audits had not been carried out on a regular basis for all MARs although the manager said they had now introduced this. Issues we identified were not always picked up on the audits and actions taken from the audits had not been effective as medication errors continued to happen. For example, missed signatures and incorrect stock counts.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• In March 2020, the local safeguarding team raised concerns about the increased amount of safeguarding concerns within the service. A meeting was held with the provider to ensure systems were in place to effectively manage these and ensure people were kept safe.
• During our inspection we found safeguarding concerns had not always been investigated with actions taken to prevent against possible harm. For example, two people had missed visits and there was no evidence to indicate what happened and actions taken.
• In June 2020, two safeguarding concerns had been raised regarding a person's catheter not being attached properly and leaking. The provider confirmed staff would be trained in catheter care to prevent re occurrences however, at the time of our inspection this training had not been completed.
• There was no provider oversight of all safeguarding incidents. A safeguarding log was in place however, this did not include all of the safeguarding concerns CQC were aware of.

This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People and their relatives said they felt safe with staff attending their homes. One person commented, "Oh yes, I have no complaints at all with the people who come out. The carer's themselves, I've had absolutely no trouble with them at all."

Staffing and recruitment
• Recruitment checks were not robust. We found two staff members who had started their training within the service prior to their references being obtained by the provider. However, they had not commenced any visits to people.

This was a breach of regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There were enough staff to visit people requiring care however, there were several incidents of missed or late visits. People's comments included, "I'm supposed to get four visits, but I get three on the odd occasion. The morning call comes at lunchtime" and "On Saturday only one person came and they [staff] had to wait in the car for someone [other staff member] to come and help. [Name] only had three visits on Saturday and Sunday instead of four. The night visit was missed out. [Name] should have had a call at 5.30pm but they came at 8pm."
• Staff told us they often had to travel long distances between visits which often caused delays. One staff member said, "I've no idea what their staffing levels are because people come and go within a month. It's hit and miss as to whether we have time in-between visits to get there." The nominated individual said they are in the process of recruiting staff locally to prevent this issue.
• In March 2020, the provider told us new systems were in place to monitor visit times however, this had not

been effective as visits continued to be late or missed.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• Not all incident and accidents had been reported to CQC. In March 2020 a person had fallen causing an injury and was taken to hospital. This incident was not reported to CQC.
• Accidents were reported by staff so further investigations could be carried out by the management team. One person said, "I did have an accident recently and it was immediately reported to the office."
• Accidents and incidents reported to management had been investigated however, on the incidents log only one out of the eight incidents from February to May 2020 had been closed with actions taken.
• At the time of our inspection there was no evidence to identify any patterns or trends from incidents to ensure lessons learnt and to reduce any apparent risks.

Preventing and controlling infection
• Staff had access to personal protective equipment (PPE) including masks, gloves and aprons to use when visiting people. However, one staff told us they had not been provided with hand sanitizer to use when visiting people. The provider said, all staff have access to PPE including hand sanitizer which is available at their head office.
• Infection control training had been provided to staff on their induction however, staff told us they had not received any specific training in relation to PPE during the Covid pandemic. The provider told us they send regular bulletins to staff informing them of any government updates and procedures for wearing PPE.

Requires Improvement

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Staff did not always have the relevant skills and knowledge to care for the people using the service. For example, some people using the service required care in diabetes, catheter and stoma care. The manager and staff told us they had not completed this training.
• Records and feedback from staff showed training was provided although this was mainly e-learning and delivered in a short time. For example, 10 courses were delivered on one day.
• Training had been completed by most staff however, we spoke with one staff member who had not updated their moving and handling training due to be completed annually.
• Supervisions and spot checks were not always completed. For example, one staff member had only received one spot check in June 2020 after being employed since November 2019. Another staff member who started working in December 2019 had not completed their induction booklet.
• Induction processes were not robust. One staff member said, they had not been given any face to face training, their induction booklet had not been checked and no spot or competency checks had been carried out prior to them completing visits to people using the service.
• We discussed these concerns with the provider. The manager told us, new systems and protocols were being implemented to ensure the induction process, training and supervisions followed best practice.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 and whether any conditions

on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• Capacity assessments had been completed however, there was no record to show how these decisions were made. This does not follow best practice in line with the act. The regional manager showed us the new template they planned to use which included a record to show how decisions would be made.
• Best interest decisions had not been completed were people lacked capacity to make certain decisions about their care for example, medicine administration.
• Staff had an understanding of the MCA and told us they always provided people with choices.

We recommend the provider follows the current MCA guidance to ensure capacity assessments and best interest decisions are completed in line with the act.

Supporting people to eat and drink enough to maintain a balanced diet, supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• Staff offered people choices of what they wished to eat and drink. People told us they were asked about their preferences and comments included, "They are always providing me with drinks and make my breakfast. They always ask me what I want" and "I get choices, sometimes you're not hungry so they will leave me something to have later."
• Choking risk assessments had not been completed for those people on specialist diets such as soft foods. The provider said they would implement these immediately.
• People told us they had access to health professionals when needed. One relative said, "Yes, they were very quick, the carers suggested the doctor who came very quick and sent [name] to hospital."

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence
• Peoples dignity had not always been respected. On multiple occasions one person told us they had been left with their catheter bag open which leaked on their legs until their next visit. One relative told us, on some visits staff had not emptied their relative's commode and had not left a drink on a couple of occasions.
• People's wishes had not always been respected. One relative said, "My mom was asked if they minded a male carer and they preferred not but they still sent them. The issues have not been dealt with at all."
• Staff encouraged people to remain as independent as possible. However, this was not always reflected in people's care plans. For example, one person's physical health and mobility had improved however, their care plan had not been updated.
• Staff respected people's privacy. One relative said, "Basically, they allow [name] space. If they are using the commode, they come in to me in the living room and wait for [name] to call. If they are helping to shower [name], they allow them to do their private parts."

Supporting people to express their views and be involved in making decisions about their care
• People and their relatives told us communication with the service was poor. People said they were not always able to speak to someone in the office about their care. One person said, "I have left a message on the phone and nobody has got back to me."
• People and relatives confirmed they were involved in their care and support. A person said, "They ask me each time they have come if everything is alright."

Ensuring people are well treated and supported; respecting equality and diversity
• People and their relatives said staff were caring. Comments included, "The carers are fine; [name] enjoys good banter with them", "The carers are really good when they come" and "Well certainly when they help me shower, I couldn't wish for better care."
• People were treated well by the staff that supported them. People's opinions about their care differed however some comments included, "They are always polite", "All in all they are all very good. I appreciate them coming. They do try to look after you properly" and "One good thing is the staff are amenable, personable and friendly."

Requires Improvement

Is the service responsive?

Our findings

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

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

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

• Care plans were not always personalised or completed. Care plans lacked information about people's preferences for care. We discussed this with the provider who said they are in the process of reviewing all care plans.

• One care plan we reviewed had not been fully completed. Some sections including the health and medication had not been completed to inform staff of the persons current needs.

• Staff we spoke with knew people well and could tell us about people's individual needs. However, one person said they had been asked by one staff member what care needed to be carried out because the care plan was unorganised and not detailed.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• The provider had carried out assessments of people's communication needs and appropriate support was provided where needed.

• The manager understood and followed the AIS. The manager told us information could be made available in different formats if required for example, items in larger print.

Improving care quality in response to complaints or concerns

• Most people and their relatives told us they knew how to make a complaint although, one person said they were unsure of how to complain.

• The provider had a complaints policy and procedure. However, we found outcomes from complaints had not always been completed. For example, a response to a complaint said a spot check would be carried out on a staff member to check their competency. There was no evidence of this being carried out.

End of life care and support

• Some people using the service were receiving end of life care. End of life care plans were not detailed and did not contain information about people's preferences and wishes. The provider told us a new end of life template had been completed to capture this information.

• Staff told us they had not received end of life training specific to meet people's needs.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support; How the provider understands and acts on duty of candour responsibility

- There was a lack of oversight, audit, assessment of the service provided and an ineffective governance structure which meant the service was not appropriately monitored. When checks were completed, they were not always effective, or robust and did not always identify the concerns we raised in this inspection.
- In March 2020, the provider was asked for re-assurances as to how they would improve care for people using the service. We were informed care and risk assessments would be detailed and improved. Staff supervisions, spot checks and audits would be completed to ensure safe practices and monitoring.
- During our inspection, we found these systems had not been imbedded within the service which meant significant improvements had not been made within this time. We found risk assessments had not always been completed, care plans lacked person-centred detail, staff supervisions and spot checks had not been consistently carried out and audits were not robust.
- Records were not always completed. MARs were not always signed by staff and stock counts were often inaccurate. One care plan we looked at had not been dated or signed to show who carried out the assessment.
- Records were not always accurate. For example, one person's initial assessment stated they wore glasses to read however, the care plan said they did not wear glasses.
- At the time of our inspection no audits had been carried out by the Nominated Individual or regional manager to ensure oversight of the service. There was no evidence of any analysis to identify trends and themes within the service such as late calls or medicine issues which we found on inspection.
- Policies and procedures in place were minimal and required further detail.
- Since the service registered with the CQC there had been a turnover of three managers. During our inspection there was no registered manager in place.
- Complaints had been responded to however, we found the actions taken had not always been carried out. For example, one staff member was due to have a spot check in March 2020 to check their competency, this was not completed.

Continuous learning and improving care

- Systems in place to monitor the service were not effective. Some quality monitoring had taken place but had not identified the issues we found.
- Audits were not consistently carried out to ensure overall monitoring of the service. Audits we reviewed had actions to be completed however, there was no information on who and when these had been completed.

We found similar issues were raised within audits which meant actions taken were not sufficient.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff and people using the service told us there was a lack of communication. For example, when visits were late people were not always informed. One staff member said, "Better communication about the changes of rotas is needed as they [managers] don't ask us they just change them. We often ring the office to say we will be late, and they don't always tell the clients."
• The service had recently introduced reviews with people to gather their feedback on the care received. People said, "Yes, they have been out twice to fill forms like questionnaires." One person said they had not been asked to give any feedback yet.

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
• The provider worked in partnership with health professionals when required.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were protected from abuse.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not robust.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of competent staff meant people were not safe. The lack of support meant staff were not enabled to carry out their role competently.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's health and wellbeing were managed safely. The lack of identifying, assessing and managing risk meant people were not always safe. Medicines were not always managed in line with best practice.

The enforcement action we took:

We issued a warning notice to the provider requesting they become complaint with regulation 12.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure robust governance systems were in place at the service. Records were not always up to date, and did not contain guidance for staff to follow about people's current care needs. Records which related to the management of the service were not well managed.

The enforcement action we took:

We issued a warning notice to the provider requesting they become complaint with regulation 17.