Your Choice 4 Care Limited

Your Choice 4 Care

Inspection report

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13 January 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Your Choice 4 Care is a domiciliary dare service providing care and support to people in their own homes. At the time of inspection, Your Choice 4 Care were delivering care and support to 13 people. Not everyone who used the service received personal care. The Care Quality Commission (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
The provider failed to operate effect systems to monitor the quality and safety of the service. As a result, we identified significant shortfalls in relation to infection control which placed people and staff at increased risk of harm given the COVID-19 pandemic. We also identified serious failings relating to record keeping, management of medicines, insufficient staffing numbers, staff training and recruitment, safeguarding and failure to notify CQC of notifiable incidents.

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 policies and systems in the service did not support this practice.

Staffing levels were not sufficient to ensure people received their care and support at the correct times and for the correct duration of time.

People and their relatives provided consistent, negative feedback about their experiences. One relative told us, "We have raised concerns about call times, my relative should have time critical medication but I regularly have to make sure my relative gets this on time." Another relative described their experience as 'chaotic', stating they often had to cancel calls because they did not know if or when staff would arrive.

The provider was unable to demonstrate any analysis of themes and trends or how learning was shared with the staff team to ensure continuous improvement.

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 the service was Good published (27 August 2019).

Why we inspected
We received concerns about missed and late calls, the management of medicines, staffing levels, poor management and staff member concerns about training. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings

from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Your Choice 4 Care on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding, staffing, good governance and failure to notify the Commission of notifiable incidents.

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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 means 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 of 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Your Choice 4 Care

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector and one inspection manager.

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

The service had a manager 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
This inspection was announced. We gave notice of the office visit, because it is a small service and we needed to be sure that the registered manager would be available to support the inspection. We also checked whether anyone was diagnosed with COVID-19, to reduce the risk of transmission. Inspection activity started on 21 December 2020 and ended on 15 January 2021. We visited the office location on 13 January 2021.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke to five members of care staff and the provider who was also the registered manager. We also spoke with five people who used the service and their relatives about their experience of the care provided.

We reviewed a range of records. This included the care records of five people including care plans, risk assessments, medicines records, daily care records and call monitoring records. We looked at three staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We continued to review records relating to infection control, risk assessments and recruitment. Following the inspection, we liaised with the local authority commissioners and safeguarding teams about our findings.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- People were at risk of contracting COVID-19. The providers policy for COVID-19 had not been updated to reflect government guidance or best practice guidance.
- Staff had not received any training in relation to the donning and doffing of PPE.
- Staff were not supported or encouraged to participate in a regular testing regime.
- Feedback from relatives was that staff did not wear appropriate PPE during care delivery and they did not dispose of PPE safely when leaving the calls.

We found no evidence that people had been harmed. However, infection control was not being effectively managed and, this placed people at increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people were not assessed, recorded, managed and reviewed regularly.
- Documentation did not reflect people's needs or related risks. For example, we identified that people's daily records were not always completed. This lack of review meant concerns about people's care and support needs were not always known and responded to.
- Risk assessments were not personalised and lacked clear guidance for staff to follow.
- Risks associated with arranging and monitoring care calls were not managed effectively.
- The provider had no systems in place for recording of incidents or accidents. Accidents and incidents were not monitored. Opportunities to learn lessons and make improvements to peoples safety were missed due to the lack of monitoring.

Whilst we found no evidence people had been harmed, people had been placed at risk of harm as a result of the issues we found. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not managed safely.
- Staff were administering medication without appropriate training or checks of their competency.
- Protocols for People who were prescribed PRN (when required) medicines was not in place. Staff did not have required information to administer PRN medication safely and effectively.
- Gaps in medication records for people were found, and medication audits of these records had failed to

identify the errors. No action had been taken to address this or prevent reoccurrence.
● The provider did not have robust systems in place to ensure the safe management of medicines.
The provider did not have robust systems in place to ensure the safe management of medicines.

We found no evidence people had been harmed. However, medicines were not being effectively managed, and this placed people at increased risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of harm or abuse. During the inspection, we identified two concerns of potential financial abuse and three concerns of neglect. We raised safeguarding alerts in respect of our findings with the local authority safeguarding team.
● The provider did not have robust systems in place to identify, monitor and review safeguarding concerns.
● Staff feedback confirmed that they could not identify all potential types of abuse and did not always understand what they needed to report.
●The providers call monitoring system identified multiple missed and late visits. This meant that people were at risk of harm by not having their care and support needs met.
● Where staffing shortfalls meant staff could not attend calls, the provider made changes to care packages without informing commissioners. This placed people at significant risk of harm of not having their needs met.

We found that effective systems were not in place to prevent and protect people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● At our last inspection we recommended the provider implemented and adhered to a robust recruitment procedure. The provider had not made the required improvements.
● There was insufficient staff to support people's needs. Recruitment was not safe.
● The provider had failed to ensure that there were sufficient numbers of staff deployed to meet the needs of people using the service.
● Staffing levels were observed to be low with a high turnover of staff.
● The provider did not operative effective recruitment practices. Records showed that one member of staff had worked without supervision before the recruitment process had been completed.
● Staff gave negative feedback about their experience of recruitment. Two members of staff reported differences in the interview process. One member of staff described the recruitment process as, "The quickest
interview I've ever had. I was just asked to fill out a form."

We found that effective systems were not in place to ensure the safe and robust recruitment process were in place, and that there were sufficient numbers of staff to meet the needs of service users. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

- Systems were not in place to effectively manage the safety and quality of the service.
- The inspection identified multiple failings within the service which had not been identified by the provider. We took urgent enforcement action to address IPC failings. We shared information with the commissioners of the service and the safeguarding team.
- People were put at significant risk of harm due to low staffing numbers and failings to meet call times as agreed. Relatives told us their family members did not always receive calls and they had to step in to provide care.

The provider had failed to implement and operate effective systems to monitor the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had failed to notify CQC of notifiable incidents that had occurred within the service. This included allegations of abuse and serious injuries.

This was a breach of regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of the inspection process in relation to this matter.

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

- People and their relatives gave consistent, negative feedback about their experience of the service. They shared examples of poor communication with the provider and staff. One relative said, "They're always late. We get a phone call much later than the call time saying they are going to be late. I just expect it now." Another relative said, "You just can't rely on them. It's like they are doing you a favour if they arrive within two hours of the call time. The communication is appalling."
- Staff told us that communication between the management team and staff was extremely poor and unsupportive. Staff said they felt overwhelmed and pressured by the provider on top of the demands of working throughout a pandemic.
- The provider had not worked in an open and transparent way with the local authority safeguarding team and CQC when accidents and incidents had occurred.

The provider had failed to promote a positive and open culture which meant good outcomes for people were not achieved. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
The provider had failed to ensure that they sought feedback from staff, people using the service and stakeholders in order to make improvements to the service.

- There were no records of staff meetings and records relating of supervision did not demonstrate how the provider had engaged with staff to seek feedback and drive improvement.
- Staff told us they felt that both the provider and director were unapproachable.

The provider had failed to engage with people and staff in order to drive improvements within the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

- There was not a culture of continuous learning. Effective systems were not in place to enable the service to improve.
- Further development of working in partnership with key organisations including local authority and safeguarding teams was required to ensure good outcomes for people.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of all notifiable incidents.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from the risk of abuse. The provider had failed to operate effective systems to ensure they reported and investigated concerns and incidents relating to safeguarding. 13(1)(2)(3)(4)(d)(6)(c)(d)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that there were sufficient numbers of skilled, trained and competent staff to meet the needs of service users. The provider had failed to operate safe and robust recruitment processes. The provider had failed to ensure staff were supported and supervised in their roles. 18(1)(2)(a)