4Life Healthcare Limited

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Inspection report

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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
4Life Healthcare Limited is a domiciliary care agency providing personal care to older people in their own homes. At the time of the inspection seven people were receiving support with personal care. An additional person passed away shortly before the inspection. We reviewed their care records too.

People's experience of using this service and what we found
Systems and processes were not effective in preventing abuse. Policies were in place but not followed. Staff did not receive enough guidance or the required training to provide safe care, therefore, people were not always protected from potential abuse.

Safeguarding issues and risks were not recognised when they should have been. The registered manager had poor knowledge of people's needs and therefore could not identify possible risks. We found some incidents had not been fully investigated or reported by the registered manager.

Staff did not receive all the training they required. One member of staff had not completed an induction into their role. Staff had limited knowledge of people's complex health conditions. No competency checks were carried out to assess the quality of care given by staff.

The care plans and risk assessments did not provide staff with enough information to ensure people received consistent and safe care. End of life care plans were not in place despite the people using the service coming towards the end of their lives.

Medicines were not managed safely. There was a lack of guidance for staff supporting people with their medication and staff were not provided with information of people's medical needs. Medicines were not recorded in a safe way and we were not assured that staff administering medication had received medicine training.

Infection control practices were unsafe during the COVID-19 pandemic. Systems were not effective in ensuring staff followed national COVID-19 guidance. This could potentially increase the risk of transmission of coronavirus.

Safe recruitment practices were not followed, as staff were deployed to work unsupervised without all necessary recruitment checks having been completed.

There has been a lack of learning from incidents occurring at the service. Effective actions have not been taken to prevent re-occurrence and concerns raised were not always resolved. The registered manager had little oversight into the day to day management of the service and there were no systems in place to identify areas for improvement or make essential changes to the service.

There was a continued lack of understanding, oversight and governance to ensure people received a safe service. Systems that were in place were not implemented effectively and audits did not identify ongoing concerns with the service.

People using the service had other healthcare professionals involved in their care. There was no evidence to demonstrate good quality multi-agency working or that professional advice was sought and followed.

There were no effective systems in place to identify and respond to complaints and concerns. We were told people had raised complaints about receiving late calls. We found complaints and concerns were not formally investigated and responded to and therefore were not assured concerns around timekeeping were responded to.

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 18 June 2019 and this was the first inspection.

Why we inspected
We received concerns in relation to care plans, recruitment, staff skills, medicines and infection control practice. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. This is where we had the highest level of concerns about the service.

We have found evidence that the provider needs to make improvements. The provider had not taken effective action to mitigate the risks. 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.

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 Regulation 12 (Safe Care and Treatment), Regulation 13 (Safeguarding service users from abuse and improper persons), Regulation 17 (Governance) and Regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify the Care Quality Commission (CQC) about incidents that occur at the service. This was in breach of regulation 18 of the (Registration) Regulations 2009.

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. These appeals have now ended. The CQC have added additional conditions onto the providers registration.

Follow up
We will review future information we receive about this service. 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 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?

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.

4Life Healthcare Limited

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of an inspector and an assistant inspector.

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
We gave the service 24 hours' notice of visiting the office location. As soon as notice was given, we began phoning people and relatives that used the service. 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.

The inspection activity started on 24 June 2020 and ended on 25 June 2020.

What we did before the inspection
We spoke with the registered manager before the inspection and found concerns with the service quality and COVID-19 management. We used our current understanding of risks at the service to focus our inspection planning. We also contacted the Clinical Commissioning Group (CCG) who commission and monitor the care of people at 4Life Health care Limited. We used all of this information to plan our inspection. 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.

During the inspection
We spoke with one person who used the service and five relatives of people using the service about their experience of the care provided. We also spoke with four members of staff and the registered manager.

We looked at the care records of seven people including care plans, risk assessments, medicines records and daily care records. We also reviewed the records of a person who had recently passed away. We reviewed other records in relation to the management of the service. These included five staff recruitment files, training records, quality monitoring audits, and the provider's policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff rotas, training data and spoke with two more care staff. We spoke with the commissioners who have contact with the service.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risks of neglect. During the inspection, we identified three concerns of neglect. These included, not providing sufficient support with food/drink without clear reasoning, no evidence of responding to a broken pressure mattress and a lack of training and guidance in managing a person's complex health condition. We raised safeguarding alerts in respect of our findings with the Local Authority Safeguarding team who take the lead role in investigating safeguarding concerns.

●These potential risks had not been identified by the registered manager prior to this inspection.

We found people were not always protected from potential neglect. This was a breach of regulation 13 (safeguarding service users from improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● The service supported people with diabetes, poor skin tissue viability, urinary catheters and stomas. Staff did not have training or guidance on how to manage these conditions. The registered manager had limited checks to ensure care was being completed safely. This put people at risk of not receiving safe care for their health conditions.

● All people using the service were coming towards the end of their life. No training had been provided on end of life care. Records showed the end of life care people had received was of poor quality. For example, one person had developed difficulties swallowing and staff had stopped providing food/drink for the last two days of the person's life. The staff did not receive training in caring for people with swallowing difficulties and there was no evidence that professional advice had been sought in response to the person's changing condition.

● Records were not regularly reviewed. This put people at risk of harm. For example, we identified that three people's daily records had not been reviewed for over two months. This lack of review meant concerns about people's changing needs were not always identified and appropriately responded to.

● Where records had been reviewed, we found potential risks had not been identified. For example, staff had recorded on a person's body map they had observed the person had developed a red mark to their skin, (indicating potential skin tissue pressure damage). However, there was no evidence action taken in response. The management team had reviewed the same body map, and had not identified the lack of detail. We were therefore not provided with reassurance of how the person's skin integrity was being monitored.

Using medicines safely

● Two people at the service received support with their prescribed medicines. Medicines were not managed

safely for either of these people. One person had support to apply a topical medicine. The registered manager was unsure if guidance on how to apply the medicine was available to staff. The person's relative explained that the staff member had searched the internet to understand how to apply the medicine. This lack of guidance risked the person receiving the medicine in an unsafe way.

● Staff did not follow good practice guidance when completing medicines records. For example, staff did not sign the medicines administration records (MAR) charts (instead they ticked the box alongside the date and time when medicines were given). This meant the provider could not assure themselves that staff had received medicine training.

● Guidance was not available for staff to follow on the administration of medicines prescribed to be given 'as needed.' We were therefore not assured that staff were guided to give these medicines appropriately.

● Staff were not provided with guidance on people's medical needs. One person was prescribed oxygen 'as needed'. A staff member told us that they did not receive training on this and would not know how to administer the oxygen if required. The lack of guidance meant the person was at risk of not receiving the oxygen safely.

Preventing and controlling infection

● Infection control practices were unsafe during the Covid-19 Pandemic. A staff member said they wore a face mask when attending to the care of a person who had tested Covid-19 positive, but not when attending to the care of people tested Covid-19 negative. This is against Public Health England guidance, which requires a face mask to be worn when working with all people using the service. This risked transmission of the Covid-19 This was particularly serious as people using the service had complex health needs and some were coming towards end of their lives.

● Another staff member was unable to wear a mask at times due to their own variable health conditions. There was no risk assessment or plan in place. Individual risk assessments had not been completed to identify which staff were most vulnerable during the Covid-19 pandemic.

● The registered manager phoned staff regularly to remind them of current Covid-19 guidance. However, staff did not have formal training in this area and there were no competency assessments of staff skills/knowledge. This meant we were not assured that staff understood the guidance to provide care in a safe way that prevented transmission of the virus.

Learning lessons when things go wrong

● The registered manager did not regularly review people's daily care notes. This meant improvements could not be made to the service. For example, we found staff did not fully record how they supported someone to reposition to protect their skin integrity, this was important to reduce the risks of skin tissue damage. A failure to review records meant gaps in recording were not identified or addressed to ensure staff provided safe care.

● Before the inspection, we received concerns about care plan guidance, staff skills, medicines and infection control practice. These concerns were brought to the attention of the registered manager and they put an action plan in place. However, we found the action plan was ineffective as the risks were still evident. There was a lack of effective action to demonstrate lessons were learnt to provide safe care.

We found people were not always provided with safe care and treatment. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff were not safely recruited. Before inspection we received concerns that staff were not safely recruited and we received assurances from the registered manager that recruitment was safe. A review of records showed the assurances were not reliable and recruitment remained unsafe during inspection.

● Recruitment records had recently been reviewed by the registered manager. They found nine staff were not safely recruited. We identified an additional two staff, who had missing references or employment history gaps that had not been investigated. The unsafe recruitment, and failure to audit recruitment files effectively, placed people at risk of being supported by unsafe staff.
● For one staff member, the registered manager could not provide evidence of an interview or competency checks. They advised the staff member had not completed an induction into their role. The staff member was working alone with a person at night. The registered manager had not checked the person's care records to see what was happening during the care visits. The registered manager could not provide any assurances that the staff member was able to provide good quality care.

Poor quality recruitment meant we were not assured that staff were safe to support people. This was a breach of regulation 19 (fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● We have previously received multiple concerns about the poor timekeeping of staff and missed care calls. This placed people at risk of not getting their needs met safely. The registered manager advised they did not complete a formal audit into staff punctuality, therefore there has been a failure to oversee these risks and make improvements. One person told us their concerns about staff punctuality had previously been addressed, but staff timekeeping was now worsening again.

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 was 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a lack of guidance in place for staff, and staff did not receive the required training. This meant we could not always be assured that all people received high quality care and good outcomes.
- People's diverse needs were not recorded. This meant we could not be assured that care was inclusive and in line with their preferences. For example, all people using the service were coming towards the end of their lives. There were no end of life care plans or other records available to demonstrate that people's personal preferences or beliefs for end of life care had been sought or how this care was to be provided.
- Staff were not provided with sufficient guidance to provide safe care. Staff and relatives told us that staff usually asked relatives for guidance instead of reading the care records. This was a risk, as relatives may not be able to provide accurate or safe guidance. This did not promote a culture of high quality, person centred care.

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

- Regulatory requirements were not met. This was because; staff did not have sufficient training or guidance, medicines were not managed safely, people were not protected from potential abuse, people were not protected from the risks of infection and staff were not safely recruited.
- We had received concerns about the service since February 2020. These concerns were brought to the attention of the registered manager, who created action plans to improve the service. We found the action plans were ineffective, and the safety of the service had not improved.
- The registered manager had policies available, which guided safe care and support. However, we found these policies were not followed. The failure to follow policies meant that people were at risk of not receiving safe care and treatment and regulatory requirements were not met.
- The registered manager had poor knowledge of people's needs. For example, the registered manager advised there were no people using the service diagnosed with diabetes. However, we identified two people with a diabetes diagnosis. Staff had not received training or guidance on caring for people with diabetes. Because the registered manager was unaware of these needs, potential risks had not been recognised and addressed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● The registered manager had given people opportunities to provide feedback on the service they received. However, individual concerns had not always been formally responded to.
● We received multiple complaints about the service that had been brought to the attention of the registered manager to investigate. However, the registered manager could not provide evidence to demonstrate the complaints had been responded to.
● Feedback had also not been used to drive improvement. We had received concerns about the service, which we had reported to the registered manager. Effective action had not been taken to improve the quality of care provided.
● The CQC and the Clinical Commissioning Group (CCG) had highlighted concerns about the service several times with the registered manager prior to the inspection. These concerns were not fully addressed or resolved, and the care people received remained of poor quality.

Working in partnership with others
● There was insufficient evidence to demonstrate that professional advice and guidance was sought and followed. For example, one person had developed multiple areas of skin tissue breakdown. There was no evidence that professional advice had been sought to guide staff on how to care for the person to reduce the risks of further skin tissue damage. Failures to seek professional advice placed the person at risk of their care and treatment needs not being met.
● People using the service were receiving end of life care and required multiple health professionals involved with their care. However, the professional's involved in people's care and their contact details were not fully recorded in people's care records. The lack of documentation had the potential to jeopardise good quality multi-agency working.

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
● Because of the poor governance at the service, the registered manager was unable to demonstrate they complied with the duty of candour.
● There was no evidence to demonstrate complaints were recorded or formally responded too. People told us of complaints they had made about the service. The registered manager explained complaints were dealt with over the phone and not recorded. The informal nature of their complaint response meant people could not be assured their complaints were taken seriously and responded to appropriately.
● People's care records were not reviewed in a timely way and audits that had taken place were ineffective at identifying areas for improvement.

There was poor governance at the service. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager is legally required to notify us of events that occurred at the service. We had not been notified of allegations of abuse. This had a negative impact on our ability to monitor the safety and quality of the service.

The failure to notify the Care Quality Commission about incidents that occur at the service is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 We found people were not always provided with safe care and treatment. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have added conditions to the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found people were not always protected from potential neglect. This was a breach of regulation 13 (safeguarding service users from improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have added conditions to the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was poor governance at the service. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have added conditions to the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Poor quality recruitment meant we were not assured that staff were safe to support people. This was a breach of regulation 19 (fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have added conditions to the provider's registration.