Family Care Agency Ltd

Family Care Agency

Inspection report

Unit 5
3 Oswin Road
Leicester
LE3 1HR

Tel: 01163260315
Website: www.familycareagency.co.uk

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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
Family Care Agency is a domiciliary home care service. The service provides personal care and support to people living in their own homes. At the time of our inspection there were 15 people using the service.

People's experience of using this service and what we found
We found people were at risk of potential harm due to poor quality risk management and there was a lack of guidance and training available for staff in relation to people's specific care needs. Medicine records were not always maintained. People and their relatives told us they felt safe, however, safeguarding systems were not always effective at protecting people from potential risk of harm. We received mixed feedback from health and social care professionals regarding the safety of the service.

There was a lack of effective systems and processes to ensure quality of care. Staff were not always aware of roles and responsibilities and the registered manager lacked knowledge in relation to safe medicine practices. Procedures were not in place to analyse care visit times to ensure people received care as planned. Feedback from people using the service and their relatives was mostly positive. However, this feedback indicated care was not being delivered as detailed within people's care plans. The provider sought feedback from people using the service through customer surveys. Staff had opportunity to raise concerns during one to one supervision with the registered manager. The provider understood their legal responsibilities with regards to duty of candour and was open and transparent during the inspection process.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 requires improvement (published 5 October 2019) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made in relation to previously identified concerns, however, new concerns were identified, and the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to the management of medicines and potential neglect of people's care needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the

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

We have found evidence that the provider needs to make improvements. 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 Family Care Agency 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding, governance oversight and staffing at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 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.

Family Care Agency

Detailed findings

Background to this inspection

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

Inspection team
The inspection was completed by two inspectors.

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

Registered Manager
This 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
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 24 August 2022 and ended on 8 September 2022. We visited the location's office on 24 and 26 August 2022.

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

During the inspection
We spoke with one person who used the service and three relatives, to learn about their experiences of the service provided. We spoke with six staff members including the registered manager. We also received feedback from four health and social care professionals who knew the service.

We reviewed a selection of care records for six people including medicine administration records, care plans, risk assessments, daily notes and incident forms. We reviewed five staff files and records relating to training, recruitment, performance management and support.

We reviewed a selection of records relating to the management and quality monitoring of the service. These included complaint management, accident and incident monitoring, quality audits, meeting minutes and provider oversight. We also reviewed a selection of policies and procedures.

Inadequate

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were at risk of potential harm due to poor quality risk management. For example, risks related to people's care needs were not always assessed in line with the providers policy before people started receiving care. This meant the provider could not be assured care staff were providing safe care that was appropriate for people's needs.
- People's care needs relating to falls were not always effectively assessed to ensure their safety. One person was at an increased risk of falls due to a change in mobility, but this risk had not been adequately reflected in their care plan or personalised risk assessments. This meant the person was put at increased risk of harm, as staff did not had access to relevant guidance on how to ensure their safety during care activities.
- There was a lack of guidance and training available for staff in relation to catheter care. For example, there was no information in people's care plans or risk assessments guiding staff how to deliver basic catheter care or how to recognise signs and symptoms of related infections. As a result, people were put at increased risk of poor catheter care. On one occasion, a person was put at potential risk of harm, as they did not receive appropriate catheter care due to this lack of guidance and staff knowledge.

Using medicines safely

- Risks associated with the use of certain medicines were not always considered or assessed. For example, the potential side effects and risks related to people taking blood thinning medications were not considered within people's care plans or risk assessments. This meant staff did not always have access to required information or guidance to ensure safe care.
- Medicine records were not always maintained in line with organisational procedure. Medication administration records did not always contain information about people's prescribed medicines. This meant people were at risk of receiving the wrong medicines or an incorrect dose, due to potential medication mismanagement.
- Medicine administrations were not always recorded. For example, care staff were administering eye drops without recording this on a medication administration record, as this document was not always made available to them. This meant the provider could not be assured care staff were supporting people with their medicines safely.

Poor risk management and unsafe medicine practices 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; Learning lessons when things go wrong

- Care staff lacked knowledge on safeguarding procedures. Care staff had received training in safeguarding,

but they lacked knowledge on how to identify signs of abuse and when to report concerns. This meant people were not always kept safe from potential safeguarding risks.
● People and their relatives told us they felt safe, however, safeguarding systems were not always effective at protecting people from potential harm. The providers system for recording and reporting safeguarding concerns was disorganised and there was a lack of follow up action taken in relation to specific safeguarding concerns. This meant people were not always protected from known risks of potential harm and opportunities to learn lessons when things went wrong were missed.
● We received mixed feedback from health and social care professionals regarding the safety of the service. The negative feedback related to substantiated safeguarding concerns of neglect of care.

The failure to keep people safe due to a lack of effective safeguarding processes 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.

● People and their relatives told us they felt safe, however, safeguarding systems were not always effective at protecting people from potential harm.

Staffing and recruitment

At our last inspection the service had failed to establish and operate an effective recruitment process. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Care staff completed a one-day training course that covered 15 essential topics, crucial to their role, including; safeguarding training, medicine management and mental capacity. However, staff lacked essential knowledge about these subjects. For example, staff did not always understand mental capacity or how it impacted the people they supported. This meant people were at risk of receiving care from poorly trained staff.
● The provider failed to identify training needs related to people's specific care needs. For example, staff were not trained on safe catheter care or dementia awareness. This meant the provider could not be assured staff were adequality trained to effectively meet people's needs.
● Staff competencies were not assessed. The providers policy stated staff were required to complete medicine competency assessments to ensure they were knowledge and skilled. There was no evidence these had been completed. This meant the provider could not be assured staff were competent to administer medicines safely.

Staff were not provided with relevant training and the provider did not assess staff competence to ensure safe care. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Feedback from social care professionals indicated care staff were not always completing the full duration of planned care visits. We found care visit times recorded within daily records did not match times staff electronically logged in and out. This meant people were at risk of not receiving the full duration of their planned care.
● The provider completed safe recruitment checks for staff prior to them starting employment. These included reference checks, health questionnaires and DBS checks: Disclosure and Barring Service (DBS)

checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● Signed consent was obtained from people in relation to their care and support. However, staff lacked understanding on the MCA and how best to support people with capacity and memory impairments. For example, staff did not have knowledge on effective dementia care. This meant the provider could not be assured they were working within the principles of the MCA.

Preventing and controlling infection
● The provider had an infection prevention and control policy in place, and it was up to date.
● Staff had access to personal protective equipment and people told us they used it when delivering care.

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 our last inspection we rated this key question requires improvement. 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

At our last inspection the registered manager had failed to maintain sufficient oversight of the service and there were no effective systems in place to monitor service quality. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Effective systems and processes were not in place to ensure quality of care. For example, processes were not in place to audit care plans to ensure they were appropriate for people's needs, and we found care plans were not always up to date. This meant the provider could not be assured the quality of care was monitored or maintained.
● Staff were not fully aware of their basic roles and responsibilities. For example, they did not always know when incidents should be recorded or reported. As a result, people were not protected from potential risk of harm.
● The provider used a data matrix to monitor staff training. However, information on the training matrix did not always correlate with the dates staff completed training. Furthermore, the provider failed to identify care needs of people using the service and provide relevant training. This meant provider oversight of staff training was not effective.
● The registered manager was not aware about safe care practices. For example, safe medicine recording practices, despite this information being readily available in the providers policy.
● Procedures were not in place to analyse care visit times to ensure people received care as scheduled, or to identify areas for improvement. This lack of oversight meant the provider could not be assured people were receiving care as scheduled, and opportunities to identify improvements were missed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Feedback from health and social care professionals was mixed. Negative feedback indicated the provider was failing to meet people's care needs. In one example, this resulted in a substantiated safeguarding investigation by the local authority, and a termination of a commissioned care package. This meant the

provider could not be assured care was meeting people's needs.
● There was limited evidence demonstrating involvement from people using the service or their relatives during care plan reviews. This was not in line with the providers policy.
● Feedback from people using the service and their relatives was mostly positive. However, this feedback indicated care was not being delivered as detailed within people's care plans. For example, staff were supporting a person with their medicines, but this was not considered in their care plan. This meant the provider could not be assured care was appropriate for people's needs.
● Information within people's care documents considered their equality characteristics such as religion and personal preferences. However, this information was not available for one person who had recently started using the service as no assessment had been completed.

The providers quality assurance systems were not effective, staff were not fully knowledgeable of their responsibilities, and the providers systems did not promote partnership working. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider sought some feedback from people using the service through customer surveys. People and their relatives told us they were satisfied with the quality of care provided.
● The registered manager told us they visited people in their own homes regularly to seek feedback and monitor care. People who used the service and their relatives told us the manager visited them at home.
● Staff had opportunity to raise concerns during one to one supervision with the registered manager and at team meetings. Staff told us the registered manager was approachable and responded to concerns or issues raised.

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
● The provider had reported safeguarding concerns to the local authority; however, they were not always aware of incidents due to a lack of staff reporting.
● The provider understood their legal responsibilities with regards to duty of candour.
● The provider was open and transparent during the inspection process.

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 Staff lacked knowledge on safeguarding and incidents were not always reported. 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.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not provided with relevant training to provide safe care and no competency checks were completed. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 providers quality assurance systems were not effective, staff were not fully knowledgeable of their responsibilities, and the providers systems did not promote partnership working. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers quality assurance systems were not effective, staff were not fully knowledgeable of their responsibilities, and the providers systems did not promote partnership working. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

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