First Choice Care Agency Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
First Choice Care Agency is a domiciliary care agency which provides care and support to people living in their own homes. At the time of the inspection there were 16 people using the service, of these 13 were receiving personal care. 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
Some improvement had been made since last inspection, however there were some areas that needed to become fully embedded. An example was medicines management, which had improved but medicines were not always managed safely.

Risk assessments were not always in place and some records lacked in detail. This was not identified by the provider's own checks.

Infection control processes were not fully embedded.

There was a lack of staffing and the provider lacked oversight of this. However, staff who were employed were recruited appropriately and had received adequate training.

Systems and processes to oversee documentation had been put in place but did not identify all concerns we found at inspection.

There was a lack of opinion sought from people and relatives, for example through customer satisfaction surveys. However, the complaints recording processes had been improved and we heard people were happy to raise concerns about their care.

People told us they felt safe and received good care. Staff understood safeguarding and knew who to escalate their concerns to.

Staff, people and relatives felt confident to raise concerns with the provider.

The registered manager was clear in their role to notify CQC and the local authority and had done so.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 23 February 2022) 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 the provider remained in breach of some regulations.

This service has been in Special Measures since 22 February 2022. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced inspection of this service on 16 December 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

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 inadequate to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for First Choice 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, governance 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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

First Choice Care Agency 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 Health and Social Care Act 2008.

Inspection team
Two inspectors attended the site, with one inspector there to shadow for their learning. Calls were made by one inspector to staff, people and their relatives in the days before and days following the inspection.

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 the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 28 July 2022 and ended on 2 August 2022. We visited the location's office on 29

July 2022.

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. 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. We used all this information to plan our inspection.

During the inspection
We spoke with two people who use the service and four family members. We also spoke with the registered manager, and three care workers.

We reviewed a range of records. This included three care records, three staff files in relation to recruitment and supervision and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not always managed safely. Medicines used to thin the blood, to prevent clots, were not always accompanied by a risk assessment and staff did not always know what the medicine was for. This placed people at risk of side effects which might not be detected swiftly by staff as they lacked the knowledge of signs to look out for.
- Topical medicines were not always accompanied by a body map. This placed people at risk of receiving medicines incorrectly. However, there was a detailed description within the 'as and when required' (PRN) protocol.
- 'As and when required' (PRN) protocols did not always contain enough detail. This put people at risk of receiving the wrong dose of medicines. PRN protocols should provide care workers with detailed descriptions about when as and when required medicines should be given. This includes information about the maximum dose in a 24 hour period, time that should pass between doses and any alternative strategies that can be tried in the place of the medicines.
- People who had diabetes were not always correctly identified as having this condition on the emergency grab sheet, which is information provided to ambulance crews in an emergency. This meant in the event of an emergency, health care professionals may not have been immediately alerted to the fact that people had diabetes.
- People's needs around support with using the toilet were not always well covered in care plans. We saw a care plan for a person who required catheter care, which did not direct staff how to manage the person's catheter. This meant it was confusing for staff to know how best to support people, especially those people with a catheter.
- The provider did not have effective processes to prevent the spread of infection when welcoming visitors to the offices.
- The provider did not always ensure personal protective equipment (PPE) was being used effectively and safely by their staff. We heard from care workers and relatives of people who use the service that for live-in

care, face masks were not always worn by care workers. There was no risk assessment for this at the time of inspection.

Systems had not been fully embedded to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of unsafe care. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection to address the concerns surrounding medicines. They told us they were going to put a risk assessment in place for care workers not wearing PPE at live-in care.

● The provider was accessing testing for people using the service and staff.
● The provider's infection prevention and control policy was up to date.
● The provider told us staff were able to receive more PPE when required from them. Staff confirmed this was the case.

Staffing and recruitment

At last inspection, there was not sufficient staff who had been appropriately trained employed at the service, this put people at risk of harm. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There were not always enough staff. Staff told us they worked multiple days in a row without a day off, and we saw evidence of this in daily care records. One staff member told us about the organisation of the office, "They are not quite properly organised. Especially when you want your days off it is a bit tricky sometimes".
● Staff were under pressure to get to all calls in a timely way. One care worker told us because of the pressures of a lack of travel time between calls, they sometimes reduced the time they were with a person. Also, through review of the rota, we identified staff were scheduled to attend more than one call at the same time. This put people at risk of not receiving their full care calls.
● People were generally satisfied with the care they received. However, one relative told us, "The care is brilliant, but the timings is not brilliant, they are sometimes late."

There was not sufficient staff employed at the service, this put people at risk of harm. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, there were not sufficient checks in place to ensure people were fit to be employed. This was a breach of Regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● Staff were recruited safely. Disclosure and Barring Service (DBS) checks were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Care workers were up to date with their training.

Systems and processes to safeguard people from the risk of abuse

At the last inspection we identified the provider did not ensure they had an effective system in place to assess capacity of the people they supported. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● People's capacity had been assessed in line with the Mental Capacity Act (MCA) 2005. The MCA is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It includes the fact that a person may have capacity to make some decisions, for example about what clothing they want to wear that day but may not have capacity to make certain other decisions, such as large financial transactions.
● People told us they felt safe. For example, one relative said "[Name] is safe and secure and has good care."
● Staff understood abuse and the forms it can take and were able to tell us what they would do in the event of identifying abuse to keep people safe.
● Staff felt confident to raise concerns with the provider. Staff were able to explain who they would raise concerns to outside of the organisation if they did not think appropriate action was taken in relation to concerns raised.
● The provider told us there were no open safeguarding investigations at the time of inspection and records we reviewed supported this.

Learning lessons when things go wrong
● Lessons had not always been learnt. Since the last inspection, there remained areas of improvement which had not been addressed such as PRN protocols as detailed above.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection records were not always fit for purpose and the provider did not ensure they had an effective audit and governance system. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider failed to maintain accurate and complete care plans, risk assessments and daily records. Care records did not contain all information needed to keep people safe and minimise potential risks. This meant staff may not know how to care for people in the correct way. For example, where next of kin had passed away, the care plans were not updated to demonstrate the new information. This may cause great distress if care workers were to talk about the deceased next of kin as if they were alive, both with the person and other relatives.
- Some audits fell short in identifying some of the concerns we found. This was because they had not included all areas of best practice within each audit. For example, the medicines audit did not cover the use of a body map for topical creams, and therefore concerns in relation to these were not identified. While there was no impact on people, this meant the registered manager had not always been able to drive the improvement needed.
- The provider could not currently evidence staff call timings due to the electronic care system in place not yet functioning fully. This meant there was not effective oversight to provide assurances in these areas. Also, daily records lacked the sign out time, this had not been identified by manual call monitoring checks. This meant care workers may not have been staying the full call duration, but the registered manager had not identified this.
- The registered manager lacked oversight of the rota for care workers. They were not aware staff members had worked one day, awake on a night shift that night and completed several calls the following day. This meant staff members may be tired, putting people at risk of care that is not safe.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider understood information sharing requirements, and knew that when concerns had been identified, appropriate notifications should be sent to the CQC and the local authority as required by law.
● Staff were clear about their roles. All the staff we spoke with understood their responsibilities, and who to go to for help should they need it.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the last inspection we identified the provider had not taken steps to act on complaints they received. This placed people at risk of harm. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16.

● The service did not have systems in place to formally ask for people's views on the service such as customer satisfaction surveys. These would have benefited the service to check if there were any improvements which could have been made. However, people and their relatives told us they were able to raise things with the registered manager when they needed to and were confident action would be taken.
● The service had improved their recording systems for communication. This included complaints, concerns and compliments and how they were processed.
● People and their relatives told us they were happy to raise concerns about their care. When we asked about sharing concerns with the registered manager if they needed to, one person said, "I am sure I will get a response."
● Team meetings were used to update staff and discuss any issues. Minutes of meetings covered areas such as infection control and were written in a supportive style.

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
● The provider understood their duty of candour. There had been no incidents reportable under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support, truthful information and a written apology.
● People and relatives were positive about the quality of care provided. One relative said, "If it hadn't been for [care worker name] provided I don't think [person] would be here. We went from a stage [person] didn't want to get up, to get washed and dressed, to eat, but [care worker name] has turned that completely around. [Person] has gained weight, [person] was losing weight before." Another relative said, "As far I am concerned, I am getting one of the best services."
● Staff told us they were happy working at the service and felt supported by the registered manager. One staff member said, "They are very good. Whenever you need help or you need some information, any time you call, you have a response."

Continuous learning and improving care; Working in partnership with others
● Systems were in place to record and monitor incidents and accidents. Action was taken to protect individuals from repeated incidents of a similar nature.
● The manager worked collaboratively with health and social care professionals to ensure that people received care which met their needs.
● The registered manager was open and receptive to feedback during our inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been fully embedded to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of unsafe care.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient staff to meet the needs of people at all times.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service. This placed people at risk of care that was not always safe.

The enforcement action we took:

Issued a warning notice