Invictus Plus Care Ltd

Invictus Plus Care

Inspection report

22 Silver Street
Trowbridge
BA14 8AE

Tel: 01225760356
Website: www.invictuspluscare.org/

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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
Invictus Plus Care Ltd is a domiciliary care and supported living service providing the regulated activity personal care. At the time of our inspection there were 42 people using the service and 23 were receiving personal care.

The provider's office is located in Trowbridge and provides care and support to people living in the local area.

Not everyone who used the service received personal care. 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
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability or who are autistic.

People were placed at risk of avoidable harm because medicines were not always managed safely. Staff were not always testing for Covid-19 in line with the most recent published guidance and this increased the risk of the spread of infection. One person's choking risk assessment was not sufficient. The provider attended safeguarding meetings when required and staff knew how to identify potential safeguarding concerns and what to do if abuse was witnessed or suspected. People were offered the opportunity to feedback about the service they received.

The provider had not always operated checks and audits to identify errors, shortfalls and omissions. There was no oversight of accidents, incidents and safeguarding concerns. The registered manager had a clear vision for the service and worked with healthcare professionals as the need arose. The registered manager was aware of their responsibility to act openly and honestly when things went wrong. The provider had recently introduced learning disability and autism training to ensure staff had the skills and knowledge to support people effectively.

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 good (published 01 October 2019).

Why we inspected
We received concerns in relation to the management of potential safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe and well-led.

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 good to requires improvement 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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Invictus Plus 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, audits and checks at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will continue to monitor information we receive about the service, 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 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.

Invictus Plus 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 Health and Social Care Act 2008.

Inspection team
The inspection team was made up of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

This service provides care and support to people living in two 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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 48 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.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed various records in relation to the running of the service, including three recruitment files and care plans. We spoke with the nominated individual who is also the registered manager, and is responsible for supervising the management of the service on behalf of the provider. We spoke with the coordinator. An Expert by Experience spoke with people and relatives by telephone.

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 good. 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.

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

- Medicines were not always managed safely. For example, when people were prescribed 'as required' medicines (PRN), there were no PRN protocols in place. This meant sufficient information was not always available for staff, to ensure these medicines were administered safely.
- Transcribed medicines entries were not always completed accurately. This resulted in gaps in information, conflicting information and increased the risk of medicines errors. For example, guidance for one person's prescribed medicines provided conflicting information about the dosage required. This meant there was a risk the person could be overdosed on medicines.
- Guidance for one person at risk of choking was not sufficient. No information was available for staff about high risk foods or what they should look for to indicate the person's choking risk had increased, which may result in the need for reassessment, and referral to Speech and Language Therapy (SALT).
- Staff we spoke with were not always testing for Covid-19 in line with the most recent published guidance. One staff member said, "I've been doing it once a week for as long as I can remember, I was doing it twice a week, but they took away the need for the PCR tests, so I do it less often now." Guidance at the time of our inspection stated testing should be undertaken twice weekly.
- The provider's system for monitoring care visits was not always effective. One person who required support with medical apparatus had a missed visit that had not been, "Picked up." This meant the person was without their assessed support throughout the night.

The provider failed to ensure medicines were consistently managed safely, and that there were measures in place to detect and prevent the spread of infection. There were additional failures to ensure one person's risk assessment was sufficiently detailed and care visit monitoring was effective. These shortfalls were a breach of regulation 12(Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection, we contacted the local authority safeguarding team about our concerns in relation to the missed care visit, risk assessment and medicines management.
- The registered manager told us they were planning a management meeting in the days after our inspection, to commence a roll out of PRN protocols.
- When staff supported people out of hours, they had access to advice, guidance and support from the on-call service.
- Staff were supported to access personal protective equipment (PPE) such as masks and gloves. Comments from relatives included, "Yes, I have always seen them [staff] in PPE."

Systems and processes to safeguard people from the risk of abuse

● The registered manager had identified there was no oversight of safeguarding in the service. At the time of our inspection, they were implementing a safeguarding monitoring tool to identify themes and trends, and review lessons learned.

● Staff spoke confidently about safeguarding and what they would do if abuse was witnessed or suspected. Comments from staff included, "I would report it [suspected abuse] immediately and record it, and if I felt the management weren't going to listen I would contact local authority" and, "I've had safeguarding training. If somebody is being abused, you can look at body language and bruises on their body, some people could give you signs like wanting to talk to you privately."

● The provider attended safeguarding meetings when required.

Staffing and recruitment

● Staff recruitment processes were in place to reduce the risk of unsuitable applicants being employed. Checks included those with the applicant's previous employer and the Disclosure and Barring Service (DBS). DBS checks are important as they reveal if a person is barred from working in care.

● The registered manager said the organisation had faced difficulty recruiting staff. To mitigate this, they had undertaken a recruitment drive abroad. They said staffing levels were sufficient to meet people's needs and the turnover of staff had decreased.

● People told us there were enough staff to meet their needs, but care visits were sometimes late. Comments from people included, "There are no set times, especially on a lunchtime it can be 12 onwards and occasionally it can be quite late" and, "They [staff] don't arrive at a set time, but before [person] gets up."

Learning lessons when things go wrong

● The registered manager told us there was no formal process of reviewing and learning when things went wrong. However, they said they had learned lessons recently about how they would assess and support people new to the service, such as ensuring a longer 'settling' period. The provider had changed their practice in line with this.

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 good. At this inspection the rating has changed to requires improvement. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Provider checks and audits had not always been used effectively to identify shortfalls, errors and omissions. For example, medicines audits were not used effectively to identify PRN protocols were absent or that errors had been made when transcribing medicines information. Additionally, checks had not identified that one person's choking risk assessment was not sufficient.
- The provider failed to operate a system that monitored staff Covid-19 testing. This meant they did not know some staff were not testing in line with published guidance.
- The provider did not have oversight of accidents, incidents and safeguarding that occurred. This meant they could not be assured they were identifying themes, trends and driving improvement within the service.
- Services we regulate are required to submit statutory notifications so that we can monitor them effectively. We found one notification was not submitted without delay. The notifiable incident had occurred in June 2022 and we were not notified until August 2022. A further statutory notification incorrectly stated the provider had made an alert to the local safeguarding team. However, the Local Authority safeguarding team confirmed they had not been contacted by the provider and were aware of the concern as a result of a safeguarding alert we raised during our inspection.

The provider failed to ensure checks and audits were operated effectively to consistently identify shortfalls, errors and omissions. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager told us they would introduce processes to monitor accidents, incidents and potential safeguarding concerns.

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

- The registered manager had a clear vision for the future of the service. They told us they wanted to remain small and intimate to ensure they could provide person-centred care.
- The service had received compliments from relatives and people they supported. One person's relative said, "We absolutely love [the] carer, she is so kind and caring and gets on with helping, cannot praise her enough" and, "Two carers who were present came across as kind and experienced in their work."
- The provider had recently started to provide care to some people with a learning disability. To provide staff with skills and knowledge needed to provide person-centred care, they had recently introduced

relevant training for all staff to attend.
● Care plans included person-centred information about how people with learning disabilities communicated their feeling using their own communication style. For example, one person's care plan provided specific details about how a person responded physically when they were upset.

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 registered manager was aware of their responsibility to act openly and honestly when things went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were provided with the opportunity to provide feedback through annual surveys. Additionally, the office operated an open-door policy so people, relatives and staff could visit to speak with the management team.
● The management team communicated with staff through a messaging application and team meetings.
● Relatives told us people did not always receive a rota with planned visit times, and names of staff who would be supporting them. Comments in relation to this included, "Regular staff. No rota. It doesn't bother me" and, "No rota. I would like that."

Working in partnership with others
● The provider worked in partnership with others. Most recently, staff had worked with a person's social worker, psychiatrist and the learning disabilities intensive support team.

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 The provider failed to ensure medicines were consistently managed safely, and that there were measures in place to detect and prevent the spread of infection. There were additional failures to ensure one person's risk assessment was sufficiently detailed and care visit monitoring was effective.

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 failed to ensure checks and audits were operated effectively to consistently identify shortfalls, errors and omissions.

The enforcement action we took:

Warning notice