2M Health & Home Care Services Ltd

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Inspection report

Suite 2, The Offices
121 Sibson Road, Birstall
Leicester
LE4 4ND

Tel: 01162666778
Website: www.2mhealthandhomecare.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
2M Health & Home Care Ltd is a domiciliary care agency. The service provides personal care to people living in their own homes. At the time of our inspection there were 32 people using the service.

Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, 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.

The service was not able to demonstrate how they were meeting underpinning principles of "Right Support, Right Care, Right Culture. This meant we could not be assured of the choices and involvement of people who used the service in their care and support. Initially the provider told us they did not support any people who lacked capacity, had a learning disability or autism or expressed emotional distress. However, we identified that there were people being supported by the provider who had multiple needs including those with a learning disability.

Right support: People were not always supported to have maximum choice and control of their lives as their care plans and risk assessments did not provide a full overview of their needs. Staff did not always support them in the least restrictive way possible and in their best interests. We found an absence of information and guidance for staff members to follow when supporting autistic people or people with a learning disability who may express distress or frustration. Care documents and risk assessments did not provide staff with information on how to respond to such expressions of distress, how to de-escalate or how to provide positive re-enforcement.

Right care: People's care and support plans did not reflect their individual needs or promote their wellbeing and enjoyment of life. People who were known to display emotional distress or frustration did not have proactive positive behaviour support plans in place. This meant staff were not equipped with the detail on specific actions to take to ensure practices were least restrictive to the person and reflective of a person's best interests.

Right culture: People did not receive personalised care that reflected their needs and preferences. Care plans failed to provide staff with clear guidance on meeting people's diverse needs. People's

communication needs were not always identified within care records and the provider was unable to evidence how specific communication needs were met.

Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

The provider was unable to demonstrate all staff had received training in relation to the Mental Capacity Act 2005 (MCA).

People were not supported to have maximum choice and control of their lives and did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk.

Rating at last inspection:
The last rating for this service was good published 16 August 2019.

Why we inspected
We were prompted to carry out this inspection due to concerns we received about catheter care, incident reporting and escalation, medicines and pressure care. A decision was made for us to inspect and examine those risks.

Enforcement
We have found breaches in relation to consent, safe care and treatment and governance of the service.

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.

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 will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means we will start processes that will prevent the provider from continuing to operate the service.
For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated inadequate for any of the five key questions, it will no longer be in special measures.

Follow up
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 will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually

means that if we have not already done so, we will start processes that will prevent the provider from continuing to operate the service.

For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

2M Health & Home Care Services Ltd

Detailed findings

Background to this inspection

Inspection team
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 carried out by 3 inspectors. An Expert by Experience made telephone calls to people using the service and their relatives. 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 homes. 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 short 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 it registered with CQC. 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 of this information to plan our inspection.

During the inspection
We spoke with 3 people who use the service and 11 relatives. We also spoke with 5 care staff including the Registered Manager who is the provider. We reviewed a range of records which included care files for 10 people. We looked at 10 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 good. At this inspection we have rated this key question inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not assessed, monitored, or managed well. There wasn't always written guidance or control measures in place to mitigate risks.
- Care plans and risk assessments were not comprehensive and lacked detail about people's care and health needs. For example, people who had an identified risk of choking had no risk assessments in place for staff to support them to eat safely, or how to respond if they choked. This lack of information meant people were at an increased risk of harm of choking.
- Where people had an identified need of becoming distressed, there was no positive behaviour support plan in place to guide staff on triggers that may make the person anxious, what to do if an incident occurred or what to do after an incident. This placed people and staff supporting them at an increased risk of harm.
- People's needs were not always fully assessed and there wasn't always guidance for staff on how to support people. Risk assessments completed were generic and did not contain enough information for staff to manage risks to people. This meant people's health and care needs may not have been met because staff did not have the information to guide them on how to meet people's needs safely.
- Care records we reviewed often contained information which contradicted prior information provided by other healthcare agencies. For example, one 1 person's NHS notes detailed a history of diabetes, but this was not noted in their care plan. When raised with the management team they said, 'We must have missed that'.
- People's health, care and support plans did not consistently include information on specific health issues, this meant there was a risk that people's health could deteriorate. For example, there was no specific guidance in place for one person who was at risk of urinary tract infections (UTI's) from an indwelling catheter.

People were at risk of not receiving safe care and treatment. We found the provider had failed to ensure risks to people's safety were thoroughly assessed and action taken to manage identified risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People's medicines were not managed safely. The provider's own medication policy stated staff must be suitably trained to administer medicines. The inspection team found 7 staff members had not completed mandatory medication training. The registered manager and field care supervisor told us, competency assessments for medicine administration had never been completed.
- Not all people receiving support with medicines had a medicine administration record (MAR) in place. This

meant there was no instruction for staff on how to administer medicines, placing them at risk of receiving the wrong dose or strength of medicine.
● There was a lack of guidance on how and where staff should apply prescribed creams. Care plans stated 'apply cream' but there was no information about the name of the cream, or how or when it should be applied, and the cream was not recorded on the medicine administration record (MAR). Body maps were not in place to provide staff with clear instructions on when, where, or how the creams should be applied. This meant people were at risk of their skin condition deteriorating if creams were applied incorrectly.
● Staff administration of transdermal patches was not safe. Staff did not record the site of application and care records did not include information on rotating the site of application. Rotating the application site is important to avoid sensitivities developing and thinning of the skin. This left people at risk of skin sensitivities.

People were at risk of not receiving safe care and treatment. People had also been placed at risk of harm as medicines were not managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk from abuse
● The provider was unable to demonstrate that all people using the service were fully protected from the risk of abuse and improper treatment.
● During the inspection, an incident occurred. The provider had failed to record the incident or report it to the relevant agencies. This demonstrated a lack of understanding and awareness of the importance of recording incidents and sharing information when necessary.
● Staff training records did not evidence that all staff had received safeguarding training.
● People using the service and their relatives gave mixed feedback about feeling safe with the service. One relative, when asked whether they feel their family member is safe said, "there are some brilliant carers and there are others who are not so good. It depends on who the carers are." Another person said, "I am very happy with [The Care Staff]."

We found the provider had failed to effectively implement systems and processes to ensure people were protected from the risk of abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider did not follow safe recruitment processes. This meant people were at risk of being supported by staff who were not of good character, or had the necessary competence, skill, or experience to support people safely.
● The provider failed to identify 10 staff members to the inspection team when they asked for these details. The 10 staff were subsequently identified by the inspection team. The provider was unable to provide any recruitment records for 6 of these staff members.
● The provider was unable to provide evidence of a Disclosure and Barring Service (DBS) check for every staff member. 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 provider had not obtained two suitable references prior to staff commencing employment, in accordance with their own recruitment policy.

The provider failed to have an established recruitment system in place and was unable to demonstrate that safe recruitment checks had been sought for all staff, this meant the provider was in breach of regulation 19(2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● There were no formal records documenting trends and patterns of incidents or how lessons learned were used to reduce risk or improve services.

● During the inspection, the provider showed us their new way of processing complaints. Lessons learned had now been added to their complaints form for any future incidents, but no new complaints had been received.

Preventing and controlling infection

● The provider was unable to evidence all staff had completed training in infection prevention and control (IPC). This posed a risk in relation to managing and minimising the risk of infection.

● There was an IPC policy and procedure in place. However, the provider had failed to follow their own policy as they did not have 'Infection Control Champions' in place, nor did they provide additional training for this role.

● Most people we spoke with said the care staff wore appropriate personal protective equipment (PPE) and followed safe practices.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- The provider was not working in line with the principles of the MCA. They were unable to evidence that people's rights under the MCA were being protected. Care planning records documented whether a person was deemed to have capacity but this had been determined before the person began using the service. This was not in line with the code of practice for the Mental Capacity Act.
- Mental capacity assessments had not been completed by the provider to determine people's ability to make particular decisions. This did not assure us that people were being supported to make their own decisions.
- The provider did not have a robust process for seeking consent from people. For example, one person's consent forms had been signed by a relative, but there was no record this person had legal authority to provide consent on their behalf. This meant we could not always be assured that people were consenting to their care.

We were not assured that the provider always ensured consent to care had been obtained. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

● The registered manager was unable to tell the inspection team whether any people using the service had specific dietary requirements. Care records indicated that some people's food and fluid intake was being recorded and other people received a diet of soft food. Care plans for these people did not highlight they required additional support.
● One family member told us, "[Service User] requires assistance with eating and drinking. Food can often be found left in front of [Service User]".

Staff support, training, skills and experience
● Staff did not receive the support they needed to carry out their role safely. Staff training records showed not all staff had completed the full mandatory training modules before carrying out care calls. This meant staff may not have the skills and knowledge to support people safely.
● Staff training records did not include any training in relation to specific health conditions such as catheter care, enteral feeding methods and end of life care. This put people at risk of receiving unsafe care from untrained staff.
● The provider sourced practical training for specific health conditions such as catheter care and pressure sore management through an internal member of staff. However, the provider was unable to evidence this member of staff was suitably qualified and competent to deliver such training.
●The provider had failed to assess the effectiveness of the training given to staff. For example, competency assessments had not been completed for any staff member.

The provider failed to ensure staff had the necessary training and competence to deliver safe care to people. This meant the provider was in breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Some people's care records indicated changes to their health and care needs, however the provider was unable to demonstrate any escalation of such changes to the relevant health care agencies.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- People's views were not clearly recorded. Care plans did not document preferred methods of communication to enable staff to support people in expressing their views and making decisions about their care.
- One person, who required a hoist to be transferred, had no details recorded regarding their preferences for this task.
- People were given the opportunity to express their views on the service, for example, people completed 'Service Users' Views Questionnaires'. However, the provider confirmed that completed questionnaires had yet to be reviewed to identify and address any arising issues.

Respecting and promoting people's privacy, dignity and independence
- The provider did not ensure that people were always treated with dignity and respect. Care plans we reviewed detailed that people 'would like to be treated with respect and dignity'. However, there was no further information or guidance as to how this could be achieved by staff.
- Care plans did not robustly record the level of support people required to maintain their independence. For example, care plans contained generic statements such as, 'carers must remember to promote my independence'.
- Relatives we spoke to were generally positive about the service and felt care staff were respectful and maintained their family members privacy and dignity. One relative told us, "Yes, they are very good with him and although we are very private they still shut the curtains and although [Service User] doesn't understand most of the time, they talk to [Service User] and tell [Service User] what they are going to do."

Ensuring people are well treated and supported; respecting equality and diversity
- Care plans only contained basic details about people and lacked information to help staff get to know people well, including people's preferences, personal histories, and backgrounds.
- The provider had not ensured systems were in place to promote good standards of quality care to ensure people were well treated and supported. For example, call monitoring systems were not monitored frequently to identify whether staff stayed the duration of the care call, or if a care call was missed. The management team acknowledged that not all care staff used the system correctly.
- Feedback about the service indicated people do not always feel well treated and supported. One person told us, "I asked for specific call times, but [Care Staff] come when it suits them. I can't rely on [Care Staff] for medication as they turn up at odd times". Several relatives told us there has been ongoing problems with

language barriers, and people are not consistently supported by familiar care staff.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant people's needs were not always met.

Planning personalised care
- People did not always have person-centred care plans in place to guide staff and ensure they received personalised care.
- People did not always receive their care at their preferred call times. Almost everyone we spoke to told us call times were inconsistent and they were not always informed about this.

End of life care and support
- The provider failed to ensure care and support plans for people requiring end of life care and support were in place. Care plans we reviewed contained vague references to funeral arrangements under the section 'end of life wishes'. This meant people's wishes and preferences may not be met as these had not been fully explored by the provider.
- The provider was unable to demonstrate they had sought advice and guidance from health care professionals to help people to have a comfortable, dignified and pain-free death.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
- The provider was unable to demonstrate they were complying with The Accessible Information Standard. The registered manager indicated they were aware of The Accessible Information Standard, but the service was not supporting any one with such needs.
- Care records indicated several people required additional support to meet such needs with no evidence of the Accessible Information Standard being implemented to ensure service users received information in a way they understood it.
- We saw barriers to communication, such as sensory loss and the need for sign language were recorded, but the risk of communication barriers was not assessed.

Care records failed to demonstrate the provision of personalised care, particularly in relation to care planning, end of life care and individual communication needs. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and system to record and respond to complaints. There was no evidence to show complaints had been analysed for themes or trends, to enable preventative work, or service improvements to be identified.

● We received feedback that most people or their relatives had not needed to raise a concern or complaint. Although, one relative told us they had raised a complaint, but the issue had not been resolved and had continued to happen during care calls.

● We also saw contact logs from people calling the office to raise problems and concerns, but such matters were not logged on the providers complaints system. The provider was unable to demonstrate these problems and concerns had been reviewed or resolved as appropriate.

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 good. At this inspection we have rated this key question 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People did not receive a service that was well-led. The registered manager did not have an adequate understanding of their role, regulatory requirements and lacked oversight of the service. Monitoring systems had not been effectively implemented to ensure oversight of the service.
- The registered manager was unable to provide adequate explanation for the issues identified throughout the inspection such as ineffective care plans and risk assessments, a lack of staff training and no competency assessments.
- The provider was unaware of the amount of people supported by the service. The number provided to the inspection team was in contradiction to the number of people detailed on the electronic care monitoring system. We were therefore not assured the people received care and support from a service that was well-led.
- The provider did not undertake robust auditing of the systems and governance across the service. Therefore, they had not highlighted the shortfalls we identified during this inspection.

The failure to ensure the service was well-led is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 – Good Governance.

Working in partnership with others

- The provider failed to work effectively with partner agencies such as the GP and District Nurses. For example, an incident had occurred where a person needed medical intervention, however this had not been acted upon until the registered manager was advised to do so by inspectors.
- There was no evidence within care records we reviewed of staff having worked with other agencies to ensure people's health needs were monitored and met.

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

- People and relatives confirmed that they were asked to complete surveys. However, only a small number of surveys were completed. No follow up work had been actioned and there was no evidence this

information had been analysed for themes and trends.
● We saw evidence staff meetings taking place and the information discussed was relevant.

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; Continuous learning and improving care
● The registered manager understood the duty of candour, they said, "It is about being transparent." However, we were not assured that the registered manager would act accordingly when the duty of candour was required. During the inspection, we were alerted to something that had gone wrong. The registered manager failed to follow the appropriate steps in reporting this matter.
● The registered manager failed to demonstrate continuous learning and improvement for themselves, or the staff employed at the service.
●Following on from the inspection, the registered manager told us they had instructed an external organisation to work with them to drive improvements.

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 9 HSCA RA Regulations 2014 Person-centred care Care records failed to demonstrate the provision of personalised care, particularly in relation to care planning, end of life care and individual communication needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent We were not assured that the provider always ensured consent to care had been obtained.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found the provider had failed to effectively implement systems and processes to ensure people were protected from the risk of abuse.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to have an established recruitment system in place and was unable to demonstrate that safe recruitment checks had been sought for all staff

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to ensure staff had the necessary training and competence to deliver safe care to people.

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 People were at risk of not receiving safe care and treatment. People had also been placed at risk of harm as medicines were not managed safely.

The enforcement action we took:

We served a warning notice on the Provider to be compliant with this regulation by 7 July 2023.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they had sufficient and effective oversight of the service.

The enforcement action we took:

We served a warning notice on the Provider to be compliant with this regulation by 7 July 2023.