First Choice Social Care & Housing Ltd

Borough of Lewisham

Inspection report

2 Laundry Mews
Herschell Road, Forest Hill
London
SE23 1RD

Tel: 02086999184

Date of inspection visit:
06 June 2022
09 June 2022
30 June 2022

Date of publication:
25 October 2022

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
Borough of Lewisham is also known as First Choice Social Care & Housing Ltd and is a care agency providing personal care and support to people living in their own homes. At the time of our inspection 16 people were 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
People gave us mixed views about the quality of care they or their relative received. We found the electronic call monitoring [ECM] data showed that some people experienced significant delays in receiving consistent care. We found insufficient travelling time led to late or missed care call visits. The provider operated an active recruitment process to recruit care staff.

The provider had systems in place to manage people's medicines. People had their medicines administered by staff that had been trained and assessed as competent and safe. However, the medicines administration records were not as robust as they could be.

The provider had systems in place to monitor the service and the quality of care. The registered manager regularly reviewed the quality of care people received in line with the provider's recommendations. However, the auditing systems did not pick up the concerns we found. The provider implemented a new care management system which is accessible to staff on their mobile phones.

The provider had an established safeguarding policy and procedures in place used to protect people from the risk of harm and abuse. Staff completed training on abuse and knew what actions to take to report any concerns they had about people's well-being.

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 6 May 2020).

Why we inspected
We received concerns about people who had experienced missed and late care visits. A decision was made for us to inspect and examine those risks.
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 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 relevant key questions 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 Borough of Lewisham on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 good governance and staffing at this inspection.
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 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. If we receive any concerning information, we may return to 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.

Borough of Lewisham

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 carried out by one inspector and one 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 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 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the registered manager would be in the office to support the inspection. Inspection activity started on 6 June and ended on 30 June 2022. We visited the location's office on 30 June 2022.

What we did before the inspection
We reviewed information we had received about the service since their registration with the Care Quality Commission. We sought feedback from the local authority and professionals who work with the service. 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 information gathered as part of monitoring activity to help plan the inspection and inform our judgements. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager. We also spoke with four people and two relatives. All staff were sent a questionnaire and we spoke to three members of staff. We reviewed a range of records. This included eight people's care records. A variety of records relating to the management of the service, including policies and quality of the service, were reviewed.

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.

Staffing and recruitment

●The registered manager had systems in place to ensure staff were scheduled to meet people's specific needs. However, we found occasions where people did not receive their care in a timely way.

● People did not always receive their assessed care due to the poor timekeeping of some staff. People told us, "There's been a couple of days when things didn't go as required and they couldn't make it in the morning", "[I] was due to go to the hospital at lunchtime but missed the appointment because carers had not got [me] ready in time," and "The handover appointment was in my home. My old carer was there but the new carers [from Borough Lewisham] didn't come. They turned up an hour late." From our conversations with people they told us that they were glad when carers turned up at all.

● We completed a review of the electronic call monitoring (ECM) data to establish the frequency and consistency of care visits. The findings from the data analysis reflected people's comments about poor timeliness of care visits. We found a third of all care calls recorded showed care workers arrived over 45 minutes late for the planned care visit time. The evidence also showed late calls were impacted by staff not having enough planned travel time between care call visits.

●The data also showed that some staff were scheduled to provide care at two different locations at the same time and the ECM data showed staff had logged their care visits at both locations as having taken place at the same time. We found the system implemented to monitor care call visits was not effective because it did not identify the issues we found.

● We received feedback from health and social care professionals who told us, "We are concerned about the timekeeping of staff." Another said, "We have received information from service users who have said the care workers are often late and they are not informed of the lateness by the office." After the inspection we received information from another health and social care professional who told us a care worker arrived four hours after the planned care call and refused to complete the evening call.

The ineffective deployment of staff created a risk to people's health and safety. This was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

● The provider had recruitment processes in place, so experienced staff were employed to provide care and support to people.

● Pre-employment checks took place to ensure staff were suitable to be employed. Each member of staff provided information to demonstrate they had right to work in the UK, with previous relevant employment histories, job references and a check from the Disclosure and Barring Service. 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.

Preventing and controlling infection

● The infection control and prevention systems were not robust. The provider had an infection prevention and control policy to safely manage the risk of infection. The registered manger and staff told us there was sufficient access to personal protective equipment (PPE) to help them to prevent and manage the spread of infection.

● Staff told us that they had enough PPE, and these could be collected from the office or they were delivered to people's homes, so the supply of PPE was maintained. However, we received comments from people using services and relatives that staff did not always wear full PPE. People told us, "They come in basic attire and just put gloves on," "They wear aprons usually and masks sometimes" and "Carers don't wear a uniform, they turn up in jeans or joggers and t shirts." After the inspection we were told by a health and social care professional that care workers were given gloves and aprons by a manager from an extra sheltered service because they arrived to provide care without any PPE. This practice increased the risk of cross contamination and infection causing potential harm to people.

The lack of robust auditing of infection prevention and control at the service failed to identify that staff were not always wearing appropriate personal protective equipment. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had recorded COVID-19 vaccinations and test results for staff.

Assessing risk, safety monitoring and management

● The registered manager ensured each person had an assessment to identify risks to their health and well-being and plan to mitigate these. People gave us positive comments about their safety, they said, "I've no reservations what-so-ever" and "I'm so fortunate to have such diligent carers." Despite these positive comments we found that risks were not always managed safely.

● Risks assessments provided guidance to staff to mitigate risks. However, staff did not always follow the risk management plans to keep people safe. For example, one person was placed at increased risk because they were not supported to use the commode when they wanted to during each care visit.

●We found another example where a person who remained in bed because the second of the required two care workers arrived one hour after the first care worker. That meant the initial care worker could not use the hoist alone to help the person out of bed.

The ineffective deployment of staff created a risk to people's health and safety. This was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not consistently managed safely. The electronic medicines system recorded details of who required support with taking their medicines. However, people described mixed views on staff's ability to support them. One person said, "The same ones come and bring the medicines" and a relative told us, "No one had turned up to give the morning meds." A relative told us they had arrived at their family member's home at 1pm and found the morning medicines not administered and gave them. The local authority safeguarding team were looking into this concern.

● The registered manager implemented a system to audit people's medicine administration records (MAR) to ensure people received their medicines as prescribed. We found that these records did not always follow the NICE guideline [NG67]Managing medicines for adults receiving social care in the community. Each

person had the name and dosage of their medicines but there were no details of the person's GP, dispensing pharmacy and time of administration. There were no staff signatures on the MARs to confirm they had administered those medicines. This practice did not follow safe and best practice and guidance from NICE.

The lack of accurate and robust medicines administration records increased the risk of harm to their health and safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager arranged a staff training programme to ensure staff were safe to administer medicines to people. The provider had a medicines policy that guided staff to ensure people's medicines were given safely.

Systems and processes to safeguard people from the risk from abuse
● The provider understood their responsibility to protect people from the risk of harm.
● The service had a safeguarding policy and processes in place to guide staff to keep people safe from harm and abuse.
● The registered manager followed the provider's safeguarding processes to investigate an allegation of abuse and to share the outcome of the investigation with the local authority and the CQC.

Learning lessons when things go wrong
● There were systems in place for the review and regular monitoring of the service.
● The provider had a process for recording any accidents and incidents these were escalated to the registered manager for investigation and to take any action as required.

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 management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

● People receiving care and their relatives did not always receive a service that was person-centred. We receive mixed comments about the support they received from staff who provided personal care. Comments from people included, "I'm delighted with the care I receive," "When [care workers] came, they didn't know how to use the sling or the hoist. They struggled with it" and "The carers don't tend to say anything to me, they talk to each other mostly in [language not known to person using the service]." These concerns were shared with the registered manager who told us they would speak to staff regarding these issues.

● Professionals who worked with the service told us they had concerns about the timeliness of care visits and that people reported care workers did not always stay the allocated length of time providing care. Our review of electronic call monitoring (ECM) data supports this view.

● People did not always receive a care service that enabled them to be empowered giving them good outcomes to their health and well-being. We received comments from people which said, "They're supposed to come in four times a day, two of them, but very often there's only one, which means they can't use the hoist" and "AM call should be 08.30hrs but one care worker came at 07.00hrs and woke [my family member] up, then one care worker came at 07.30hrs." We were also made aware of another occasion where a person involuntarily remained in bed because two care staff did not arrive on time as expected. This meant that staff had not provided appropriate care to meet people's individual assessed care.

● People did not always know what the care package was to support them each visit. People commented, "What's that? [care plan] I suppose I have one but I haven't seen it" and "The care plan (in the bathroom) hasn't been changed for a while, maybe two years." We noted that each person had an assessment and care plan held by the provider, however people we spoke with did not always have a copy.

The ineffective deployment of staff increased risks to people's health and wellbeing. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Continuous learning and improving care

● The registered manager had a commitment to continuous learning and improvement at the service. There were established systems in place to monitor and review medicines management, rota management, safeguarding incidents and accidents and incidents.

● The registered manager routinely monitored the quality of care provided to ensure this met the provider's standards. However, care management and auditing systems did not alert the registered manager to the multiple concerns we found about care visits, management of medicines and infection control

The poor service monitoring increased risks to people's health and safety. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The registered manager did not fully act on or understand their responsibility to show clear leadership of the service. The management systems did not provide an overall insight into the quality of care and service delivery.

● Care staff understood their roles to ensure people received a care service that was of good quality and that met people's needs. However, the evidence we have found and reviewed showed people did not always have good and consistent care outcomes.

● The registered manager understood their legal responsibilities to inform the Care Quality Commission of incidents and events that occurred at the service in a timely way.

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

● The registered manager took action to gather feedback from people about the care and support they received. There were systems in place for people to give their feedback about the quality of the service. Feedback was received through surveys of the service. The feedback from the annual report showed, "Poor feedback related to timeliness. We will be more proactive with our allocation of workers to ensure we have enough back up when we lack capacity especially weekend." These findings are consistent with what people, their relatives and health and social care professionals told us and in the review of ECM data.

● Staff meetings took place with care workers to share information with them about any changes that occurred in the service.

● Staff told us they were provided with meeting minutes if they could not attend. Meetings were held online so staff could contribute and share their ideas and views with their colleagues.

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 understood their responsibilities in relation to duty of candour.

● The registered manager told us that they operated in an open and transparent way and knew they had a legal responsibility to share information with the local authority and the CQC when things go wrong.

Working in partnership with others

● Staff worked in partnership with colleagues from health and social care services so people could have access to consistent care and advice when required.

● Records showed that staff frequently contacted health and social care professionals for advice and support when people's needs had changed.

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 there were effective systems in place to manage people's medicines safely. 12 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to effectively assess, manage, monitor and improve the quality and safety of the service. Regulation 17 (1)(2)

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 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were deployed in an effective way to meet service users assessed care and support needs. Regulation 18 (1)(2)

The enforcement action we took:

Issued warning notice for regulation 18