Leader Care Ltd

Leader Care

Inspection report

Airedale House Business Centre
423 Kirkstall Road
Leeds
LS4 2EW

Tel: 07484101038
Website: www.leadercare.co.uk

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28 May 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Leader Care is a domiciliary care service. It is registered to provide personal care to people living in their own homes in the community.

Not everyone who used the service received personal care. The 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. At the time of our inspection, three people were receiving a personal care service.

People's experience of using this service and what we found
The provider was failing to effectively assess, monitor and improve the quality and safety of the service and to assess and manage a range of potential risks to people's safety and welfare. The leadership, management and governance arrangements did not provide assurance the service was well-led. Quality assurance and governance arrangements had not been reliable or effective in identifying shortfalls in the service.

Information relating to people's individual risks were not always recorded or mitigated and did not provide enough assurance that people were safe. Suitable arrangements were not in place to always ensure the safe management of medicines and this placed people at risk of harm.

Lessons were not consistently learned to improve the quality of care for people using the service. The provider's response to the COVID-19 pandemic was inconsistent and increased risks to people's health. Appropriate measures were not in place to prevent and control the spread of infection.

Recruitment procedures were not always robust enough to ensure suitable people were employed. Staffing levels were maintained. However, changes to calls were made without discussion with people and there was no analysis of missed or late calls to prevent them happening again.

A person and a relative we spoke with were satisfied with the care and support they or their family member received from individual staff. They described staff as kind and caring. However, they said arrangements to communicate with them were not effective; for example, they did not know which staff were coming to provide their care. Care plans covered people's individual care and support needs. Improvements were still required to ensure each person's care plan was up to date and accurate.

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 17 December 2020) and there were multiple breaches of regulation. The provider told us after the last inspection what they would do to improve. At this inspection we found insufficient improvement had been made and the provider was still in breach of

regulations.

Why we inspected:
This was a planned inspection due to an increasing number of concerns being raised with us about the safety, management and leadership of the service and to follow up on action we told the provider to take at the last inspection. The inspection was focused on the key questions of Safe and Well-led. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Leader Care on our website at www.cqc.org.uk.

The overall rating for the service remains Inadequate. This is based on the findings at this inspection.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection we have identified continued breaches of regulations in relation to the assessment and management of potential risks to people's safety; medicines management; infection prevention and control; recruitment; staffing; governance and leadership 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.

Follow up:
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the registered person's registration, we will re-inspect within 6 months to check for significant improvements.

If the registered person has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the registered person from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we re-inspect it and is no longer rated as Inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Leader 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 Care Act 2014.

Inspection team
The inspection was conducted by two inspectors.

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

The service did not have a manager registered with the Care Quality Commission at the time of inspection in line with the requirements of the provider's registration. The provider had recruited a manager who resigned during the inspection but then rescinded their notice and returned to post. This means that the nominated individual is legally responsible for how the service is run and for the quality and safety of the care provided. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
This inspection was unannounced. Inspection activity started on 26 April 2021 and ended on 28 May 2021. We visited the office location on 28 May 2021.

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 prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke by telephone with one person who used the service, one relative and one health professional about their experience of the care provided. We spoke with four staff by telephone. We spoke with the manager, and the nominated individual by telephone and during the site visit. We reviewed a range of records, this included three people's care records. We looked at three staff files in relation to recruitment and training. A variety of records relating to the management of the service, including policies and procedures were also reviewed. We liaised with the local authority when we had concerns we needed to share with them to ensure people's safety.

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

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to properly assess and manage a range of potential risks to people's safety. They had also failed to ensure medicines were managed safely. This was a breach of Regulation 12 (Safe care and treatment) 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.

• Risks to people's safety were not adequately identified, mitigated or monitored. Information in risk management plans lacked detail and guidance for staff. One person's care assessment said they had 'trouble with swallowing'. There was no assessment or management plan for the risks of choking. Another person's care plan indicated they had thickening powder in drinks. No risk assessment for choking had been carried out for this person. Staff told us the person was at risk from choking when having their teeth cleaned; the manager said there were no risks. It was not therefore clear if there was a risk to this person. We asked the manager to review this.
• Falls risk assessments were not robust or consistent with people's needs. One person's records stated there were no environmental risks related to falls. However, further documentation indicated there were risks. A person had bed rails to protect them from falls from bed but no risk assessment of bedrails had been carried out to ensure safe use.
• Risks to people's skin integrity were not fully identified. Records did not identify the areas where people were at risk from pressure damage.
• Records were not always completed to show staff received moving and handling practical training.

Using medicines safely
• Medicines were not managed safely. Information in care plans was inconsistent with people's needs and could lead to errors in medication administration. One person's records did not identify the actual support they needed with their medicines. Another person's care plan said they did not have prescribed creams when they did. The manager agreed to review this.
• The provider had a medicines policy in place. However, this was the local authority policy and had not been reviewed or adapted to the service.

Preventing and controlling infection
• The provider's response to the COVID-19 pandemic was not consistent with government guidance. There

was no system in place to ensure staff were taking weekly COVID-19 tests; despite this being the current government guidance for domiciliary care providers. The provider had not assessed the risk of staff who were not confirmed as vaccinated against COVID-19 but were providing personal care to people.
• Staff received infection control training and had been assessed in putting on and taking off personal protective equipment (PPE) safely. However, two staff could not correctly describe the procedure for removing PPE safely. One staff member when corrected regarding this, disputed the issue with us. It was clear they were not following government guidance. Another staff member did not know the correct procedure for waste disposal.
• The provider had identified people and staff who could be at higher risk of more significant effects of COVID-19. However, where risks for staff had been identified, there were no actions recorded to reduce risks.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety, medicines, infection prevention and control was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure people were protected from abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 13.

• Systems to safeguard people from potential abuse and ill treatment were not robust. Actions from incidents were not completed to improve people's safety. One person had a fall during moving and handling and the recorded action of re-training staff to reduce future risk had not been followed. The family member of this person had also expressed a preference that staff involved in this incident did not provide future care. The provider had failed to respect these wishes and the staff member returned to provide their care.
• Accidents, incidents and concerns were logged. Records did not include the recent complaints and concerns raised by the local authority. We were therefore unable to identify any actions taken and lessons learned.
• People's consent to their care had been considered as mental capacity assessments were carried out. However, one person's records described them as confused and their capacity assessment did not identify this. There was a risk their rights may not be respected due to this inconsistency.
• The provider's safeguarding and whistleblowing policy did not include the contact details of all local authorities commissioned with. Staff did not know where to find this information.

The provider's ongoing failure to ensure people were protected from abuse was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• A person and their relative said they felt safe with staff who were kind and caring. One relative said, "The carers have been brilliant; they have got [name of family member] back on their feet again."

Staffing and recruitment

At our last inspection the provider had failed to ensure recruitment procedures were robust. This was a

breach of Regulation 19 (Fit and proper persons employed) 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 19.

• Systems to safely recruit staff were not robust which could place people at risk from unsafe care and support. The provider was not always able to show staff had been robustly selected and their competence checked before they worked unsupervised in their role.
• Interviews were not always carried out by two staff, as recommended in the provider's policy. The scoring system was not followed on all occasions, which meant staff who did not score highly in interview were then employed.
• Shadowing (working alongside a senior staff member) records were not available for all staff. Those we did see lacked detail and did not show how long staff spent shadowing to ensure their suitability.

The provider's ongoing failure to take proper steps to ensure new recruits were suitable to work with vulnerable people was a continued breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure the safe and effective deployment of suitably trained staff to meet people's needs. 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.

• A person and their relative told us there had been a high staff turnover and they did not always know who would be coming to attend their call. One person said, "It makes me very anxious". A relative said, "We never know who is coming; don't get a rota, so many changes. The routes and timings seem so bizarre." They added, "Managers seem to have impossible expectations of timings. They don't allow enough time." Staff raised concerns at the number of staff available to cover people's calls. One said, "Staff are leaving and [provider] can't recruit as there are so few hours."
• A relative told us their family member's call times had been changed without any consultation with them. This meant their family members bedtime call had been brought forward to teatime and they did not wish to go to bed at that time.
• Call monitoring had been introduced. There was no overview or analysis of this. Action taken was vague for example 'contacted worker' no record on what was done to prevent future reoccurrence of any late or missed calls.

This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to assess and monitor the quality of the service and take action to address a wide range of potential risks to people's safety and well-being. This was a breach of Regulation 17 (Good governance) 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.

• There were ineffective quality assurance systems in place to assess, monitor and improve the quality of the service. Some quality audits were carried out but still failed to fully identify areas for improvement. We found breaches of regulation relating to risk management, medicines, infection prevention and control, staffing, training, safeguarding, recruitment, management and record keeping. These widespread failings demonstrated the provider did not fully understand regulatory requirements.
• People, relatives and staff reported poor leadership and management in the service. A person who used the service said, "I never know who is coming; it is poor organisation really." A relative said, "So many changes; staff and management. We don't know who is coming, have to guess." Comments from staff included; "Management are not that good. They don't communicate well, they don't know what is going on" and "Don't feel we are heard when we raise things, for example the safety of the hoist for [name of person]." Another staff member said, "[Name of provider] just won't listen; the service is in crisis."
• Since the service registered with the CQC in 2019 there has been a turnover of four managers. During our inspection there was still no registered manager in place. A manager had been appointed; they resigned during the inspection and then we were told they were back in post. Staff told us they did not know if the manager was working for the service or not. The provider gave us staff lists that were not accurate in terms of which staff were currently working for the service.
• Some records were not available for the inspection, this included logs of safeguarding, incidents and complaints for 2020 and some staff shadowing records. The provider told us staff who had left the service still had these records and they had not been able to secure their return. This demonstrated poor oversight of the service from the provider.
• Some complaints were responded to. However, complaints raised by people with the local authority and

referred on to the provider had not been recorded. We could not be assured the concerns within these had been responded to by the provider. Other complaints recorded on the complaints log showed a lack of action in the response. For example, a request to not have a staff member carry out a care call was not adhered to.

The provider had failed to operate effective systems to regularly assess and monitor the quality and safety of the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Relevant statutory notifications had been submitted to CQC, to inform us of things such as accidents and safeguarding matters.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• We found inconsistencies in records which meant we were not assured appropriate care was provided. Care records referred to equipment no longer used for a person and did not include management plans for known risks such as choking. Another person's records said they did not have prescribed creams when they did. Care records audits were checklists on records that should be in place and did not review quality and accuracy of them.
• Care records contained vague terms such as 'support' and 'assist' when describing people's care needs. There was a risk this would lead to care needs being overlooked. One staff member was not aware of the support a person needed to prevent choking when cleaning teeth. Staff and the manager gave inconsistent views about mobility assistance for a person when showering. Daily records were not a contemporaneous record of the care given to people. The manager told us they were aware of this, but no action had been taken to address it.

The provider had failed to maintain an accurate and complete record in respect of each service user's care and treatment. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Although staff spoke of the enjoyment they had in their job role; feedback on support they received from the manager and provider was mixed. Comments we received included; "I don't trust [name of provider], I don't think they understand care", "On call don't always get back to you, depends who is on, it can be stressful" and "[Name of manager] is making improvements, turning things around."
• The training policy indicated staff who were responsible for training others would have regular tuition on coaching skills. There were no records maintained of this. One staff member said they had meetings with office staff to discuss how to do spot checks. The provider told us they had overseen staff's performance regarding moving and handling. There was no evidence of training to enable them to do this.
• Records showed staff received training when they commenced their employment. However, a high number of courses were delivered over a short period time. For example, nine topics in one day. A staff member told us, "It's a lot to take in, I am behind with all the reading." The service provided end of life care for people. Staff did not receive training in this but were able to describe how they cared for people with compassion.
• 'Service user feedback forms' had been introduced and some recent feedback showed some satisfaction with the service. There was no analysis of these to identify any patterns or trends. Actions taken in response to issues raised were not recorded and records showed issues were repeated. For example, a person said they were not happy with call times in February 2021 and again in April 2021.

Working in partnership with others

• The service worked in partnership with the local authority and health professionals. A health professional we spoke with said, "Things are going well now; a few teething problems to start with, such as staff not being trained to use the particular hoist. They have been responsive in sorting this out though."