CSN Care Group Limited

MyLife (East Sussex)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
MyLife (East Sussex) is a domiciliary care agency providing personal care to people living in their own homes. They cover Brighton and Hove, East Sussex and West Sussex, and have an additional branch office in West Sussex. The service provides support to people with a wide range of different health care needs. At the time of our inspection, there were 143 people using the service. 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
People did not always receive consistent and reliable care. Several care calls had been missed in recent months. Care call scheduling was not robust with some calls not covered on the day of our first site visit. We addressed this with the area manager and action was taken to improve this, we completed a second visit a week later and saw improvement.

Staff training was not up to date. Some competency checks had been completed however there remained a risk that not all staff had the correct skills and experience to provide safe care to people. Record keeping at the service was inconsistent, for example medicine administration records contained gaps. This was due to an issue with the electronic care system, not that the medicine was being missed. This was an area being addressed by the quality lead.

There was a lack of managerial oversight at the service. The quality assurance processes had not identified and addressed the concerns. Accident and incidents were not routinely reviewed to identify and address any themes or patterns in order to improve the service. The area manager was placed in the office following our first site visit until a new manager could be recruited.

People told us they felt safe with care staff in their homes, and most spoke positively about the care they received. We received mixed feedback from people regarding being given the opportunity to improve the service, however people told us they felt able to contact the office should they have any concerns.

People were treated with respect and dignity by care staff who knew their needs and preferences well.

Care plans and risk assessments contained information to guide staff on how to support people in the way they preferred and minimise risks. The provider had an up to date safeguarding policy in place and staff demonstrated good knowledge of what to do should they have concerns.

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 18 February 2021).

Why we inspected
We received concerns in relation to care calls being missed, cancelled and not scheduled effectively. We also received concerns that incidents were not being thoroughly investigated. There were also concerns over a lack of managerial oversight at the service and negative culture within the office staff. As a result, we undertook a focused inspection to review the key questions of safe, caring 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 safe, caring 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.

Since our inspection the provider has supplied an action plan detailing how they are addressing our concerns and minimising risk to people who use the service. This includes the area manager overseeing the management of the service, more robust scheduling of care calls, and arranging training.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for MyLife (East Sussex) 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 people receiving safe and consistent care, staff training and managerial oversight of the service.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

MyLife (East Sussex)

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by 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.

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 not a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 20 June 2022 and ended on 29 June 2022. We visited the location's office on 20 June and 27 June 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 spoke with 12 people who used the service and three relatives to gather their view on the care received. We spoke with eight members of staff including the area manager, office co-ordinators and care assistants. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed six care plans, a range of medicine administration records (MAR), three staff files and other records relating to the quality and safety of the service.

After the inspection
We continued to review evidence provided by the area manager. This included another three care plans and a number of competency check documents. We sought further feedback from the local authorities who worked with the agency.

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

● People were not receiving a consistent and reliable service. Issues with the scheduling of calls had led to calls not being scheduled until the day of the care provided leading to potential missed calls or calls being changed to fit scheduling. For example, calls which required two carers being completed by one carer. The provider did have a RAG rating system which had been implemented. A RAG rating system allowed the service to prioritise calls which were critical and rearrange or cancel those which were not. We saw that some time critical calls had been missed which included support with medicines and meals.

● People's feedback regarding the consistency of care and the timing of calls within agreed appointment times was mixed. Comments included, "Some days it's better than others, we're not told in advance, you just wait and see whether they turn up", "No, they're not usually on time, but that's life, they can't help it" and "It varies, sometimes if they get stuck at another call they can sometimes be late. The call before me can take longer but that can't be helped. It's usually the same carer I have and they phone to say if they're running late, the carer not the office."

● There had been several missed calls in recent months. These calls included missed meals and medicines and were deemed as critical calls according to the person's care plan. We saw that home visits or checks to follow up after these missed calls to monitor people's welfare and whether people had taken their medicines had not been completed.

● The provider had a 'no show' policy, where if a carer attended a person's property and they were not there, a procedure had to be followed to ensure their safety. Due to the poor record keeping regarding missed calls, it was unclear whether the policy had been followed on one occasion. Record keeping training was being planned for staff members to prevent this occurring again.

● There were sufficient staff to cover the calls, short notice sickness added to the difficulties in scheduling. Feedback about the level of available staff in the service was mixed with people speaking of their frustration regarding not knowing which carer will be arriving when. One person told us, "It comes and goes staffing wise, they usually send me somebody and mostly the same people. Not so much recently with everything that has been going on." Staff members told us, " The rotas have got really bad recently. It's hard to tell whether it's a staffing issue or the office." Another said, "The office organise all of the calls. I don't know if there's enough staff. The girls do the best they can from the office. Some more travel time would be nice."

Systems had not been utilised correctly to ensure all care calls were covered. Some calls had been missed and some hours were not yet allocated which put at risk people's health, safety and welfare. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff training was not up to date. The service's training matrix showed that less than 50% of staff had

completed refresher training in mandatory training such as safeguarding, medicines and manual handling. This meant there was a risk that not all staff were suitably qualified, competent, skilled and experienced. Some competency checks had been completed; however, these were not regular or robust enough to provide assurances that staff were completing their role safely.

The lack of up to date training of staff placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection and sent us an action plan of how the concerns would be addressed. By the second site visit, improvements had already been made to the scheduling of calls and the training of staff. These improvements need to be fully embedded over time.

● Staff were recruited in a safe and robust way. This included pre-employment checks such as character references and a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to investigate and address safeguarding concerns raised. People and relatives told us they felt safe with care staff in their home. Comments included, "Yes, I am totally comfortable with them in my home. I trust them 100%", "Oh gosh I feel safe with them. In fact, I feel safer with them here, they know me better than I know myself" and "Yeah, we're safe. They use the door lock. I'm happy for them to have the code."
● Some staff annual refresher safeguarding training was overdue. Staff we spoke with demonstrated knowledge of what to do should they suspect someone is experiencing or at risk of abuse. One staff member said, "I have done that training. I would notify the office and do what they say. Luckily I've never been in that situation but I'd be confident to raise my concerns and [management] would follow up."
● The provider had up to date policies and guidance available to support people and staff in acting on and investigating concerns.

Learning lessons when things go wrong
● The system to record and follow up accidents and incidents was not robust. For example, we saw falls documented on part of the electronic system, these were not documented in the accident and incident folder. This meant that audits were not undertaken to allow follow up actions to be taken and lessons learnt were not evident.
● The missed calls log contained information regarding the calls that were missed. This had not been audited since July 2021. The detail on the documents was brief and did not provide enough information to ensure lessons were learnt. For example, one person missed a call as they did not answer the door, from information on the missed call log, it was unclear whether the provider's 'no answer' policy was followed. Both points were raised with the provider who was taking action to remedy this.

Assessing risk, safety monitoring and management
● Risks were assessed and managed we saw some conflicting information in people's care plans. For example, one person's care plan stated they were at risk of falls but there was no falls risk assessment present. The person had not experienced a fall whilst receiving care from MyLife. This was raised with the quality officer who advised they are completing a full review of care records and this will be amended to provide clearer guidance.
● Where risks had been identified, there was clear guidance and staff knew how to minimise these risks for

people. This included any specific environmental risks to consider when entering a person's property alone.
● There was an on-call system in place for any incidents which occurred outside of office hours to be reported and risks minimised immediately.

Using medicines safely
● Medicines were not always consistently recorded. Some Medication Administration Records (MAR) were missing initials where medicines had been given. This was due to an issue with the call log electronic system and not people's medicines not being administered. This increased the risk of people being given medicine incorrectly. This was highlighted to office staff who have arranged additional training in record keeping so improvements could be made.
● People told us that they received their medicines correctly in the way they had been prescribed. Protocols were available for any medicines prescribed 'when required' to make sure these were given when appropriate.
● Audits of MAR charts were undertaken regularly to make sure staff were managing medicines correctly. We saw actions had been taken to address any issues, for example, prescribing instructions being made clearer.
● Staff who administered medicines had regular competency checks to ensure they were working in line with best practice.

Preventing and controlling infection
● We were assured that the provider was using personal protective equipment (PPE) effectively and safely when providing care in people's homes. People told us that staff worn PPE appropriately during their care calls.
● We were assured that the provider was accessing testing for staff.
● We were assured that the provider's infection prevention and control policy was up to date.

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 the rating has changed to 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 were not always involved in decisions about their care and feedback around this was mixed. One person told us, "[Staff] never ask, they don't look at the book at what needs doing, they are always in a rush." Another person said, "Mostly we get the same carers and they know us both well. Occasionally we get someone we don't know and have to explain what they need to do and what we like."
- Care plans had not been regularly reviewed and updated. We saw a quality compliance document which showed not all care plans were up to date. It was unclear in the records whether people had been involved in these reviews. One person told us, "I don't have much to do with the office. But the girls that come here are very good. They treat me well." An office staff member confirmed that they were in the process of reviewing all care plans and we saw evidence of this happening during our second office visit. Feedback was given to the provider, who has an action plan to address the issues identified.

Ensuring people are well treated and supported; respecting equality and diversity

- People were complimentary about the care staff who they knew well. Comments included, "They are out of this world" and "As long as they can keep coming and helping me the way they do, I'm happy."
- Care plans included a section on people's cultural, religious and gender preference of carer. Where people preferred to have a certain carer, this had been facilitated where possible. We saw evidence of measures taken to communicate with a person whose first language was not English. This showed the service tried to meet people's preferences in a caring and kind manner.

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and their rights to privacy and independence were respected. People and relatives told us staff treated them with dignity and respect. One person told us, "Yes they always ask my consent and explain what they will be doing before doing it. I feel totally comfortable and they would never do anything I hadn't asked for."
- Staff told us about the importance of ensuring people's privacy and dignity was supported. They told us, " I go to the same clients, I know their routine. I talk to them and ask what they need and if its ok before I do stuff."
- People's information was stored in secure electronic care records to promote privacy. Other information regarding the monitoring of the service was stored securely in the office.

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.

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

- There was a lack of robust managerial oversight at the service. We identified breaches in relation to the management of care calls leading to people missing medicines and meals. We also identified that a portion of staff refresher training was overdue. These issues had not been identified through the existing quality assurance processes at the service.
- The service did not always have an effective system in place to monitor and identify shortfalls in care. We saw some evidence of audit documents which had been completed. There was no oversight over certain areas. For example, accident and incidents were not monitored for patterns and trends to identify learning points and areas of improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Staff from the office and management did not always communicate effectively with people. We received mixed feedback about communication from the office, especially regarding late or missed care calls. Comments included "Sometimes it alright and other times it not. We've never had surveys and we don't get calls to ask how things are" and "The office don't call me to let me know someone will be late. It would be nice if they could, so I know what's going on."
- There was no registered manager at the service at our inspection. People were not aware of the recent management changes in the service. One person told us, "The last manager I spoke to was [name]. I haven't spoken to any manager recently, I wouldn't know who it was" and "No I do not really know who the manager is, there used to be [name] but I don't know who is in charge now."
- Feedback from staff about the changes in the service and the management team was mixed. Some staff told us, "It's a little concerning that there have been three bosses since I started. I'm not sure what that's about" and "I don't think we have a manager at the moment. But I can contact the office anyway if I'm concerned."
- The area manager had a good understanding of the duty of candour. However, one person did tell us that they had not received a clear outcome or apology regarding a matter they raised under safeguarding. This feedback was given to the area manager for improvements to be made moving forward.

The provider's governance systems were not being operated effectively enough to minimise the risks associated with them. This placed people at risk of harm and represents a breach of regulation 17 (Good

Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual provided an action plan which contained assurances regarding the consistent managerial oversight at the service. This had been implemented by our second site visit however, would require additional time to embed fully and provide consistent quality of care.

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

● People and staff were not always asked for their views or engaged with development of the service. We saw some evidence of quality assurance calls being made to people, these were the service's main way of gathering feedback on care and had not been completed routinely. One person told us, "No I don't get calls or surveys, but I can contact them if I have any concerns and I'm sure it would be dealt with." The area manager confirmed during our second visit that new questionnaires were being prioritised to be sent to people.

● We saw evidence of meetings taking place with the staff team. One staff member said, "I think I've had three meetings. [Management] tend to just address issues as they come up." Office staff had a separate meeting to discuss any issues that needed addressing.

Working in partnership with others

● The service worked in partnership with others. One local authority told us that they had a good working relationship with the service. Another told us that they had no concerns about the agency, but that communication could be improved.

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 did not have a robust system to ensure all care calls were covered. Some calls had been missed, late or cancelled which put at risk people's health, safety and welfare.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers systems to monitor the quality of the service were not identifying areas for improvement.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure the system for providing and monitoring staff training was effective and up to date.