LMT Realty Ltd

LMT Support Care

Inspection report

13 Perlethorpe Close
Gedling
Nottingham
Nottinghamshire
NG4 4GF

Tel: 07840471939
Website: www.lmtservices.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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
LMT Support Care is a domiciliary care service providing personal care to 3 people at the time of the inspection. 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's individual risks and safety were not effectively monitored by the provider. Medicines checks were not regularly carried out and we were not assured all the staff had received the necessary training. Staff had access to enough personal protective equipment (PPE) to be able to support people safely and in line with COVID-19 guidance.

Processes and procedures were not in place to reduce the potential for abuse, and the provider did not have records available of whether all staff had received safeguarding training. The provider had not carried out necessary pre-employment checks on their staff, which meant there was an increased risk that unsuitable people might be employed to support vulnerable adults.

People's care plans did not always contain all the relevant information needed to guide staff and ensure the person received appropriate care and had given their consent to be supported. The provider had no training records available for the care staff. No records were kept of any checks to determine staff competency to carry out key tasks; such as the administration of prescribed medicines and moving and handling tasks.

The provider was not open and honest. During the inspection they had attempted to mislead the CQC inspector, about the people being supported and the staff employed. The manager was not clear about their role and responsibilities.

The provider had no policies and procedures in place at the time of the inspection. They also did not have effective systems and processes in place to assess, monitor and improve the service they provided to people.

Relatives told us the manager was not easy to contact and did not routinely provide them with information about the service being provided to their loved one.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. Although staff worked in this way, the provider did not have any policies and systems in place to support this practice.

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 9 April 2018).

Why we inspected
The inspection was prompted by the provider's failure to send requested information to the CQC as part of a Direct Monitoring Activity carried out on 22 September 2021.

A Direct Monitoring Activity consists of a review of the information the CQC hold about a service and a structured phone call with the provider. The aim is to use the information from that activity to obtain assurances about the service, and any potential risks, without the need to carry out an inspection. However, adequate assurances were not obtained, and a decision was therefore made for us to inspect and examine those risks.

We had concerns in relation to the provider's management processes and record keeping. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led key only.

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.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report. The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to 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.

We have identified breaches in relation to the care and treatment arrangements at the service, arrangements for protecting people from potential abuse, and the management of the service.

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

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

Follow up
We will request an action plan for 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 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 is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider 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 provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the provider's 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 inspect it, and it 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

LMT Support 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 carried out by one inspector.

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

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 72 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included the responses we received from the provider during the Direct Monitoring Activity phone call on 22 September 2021. 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 with one person who used the service and two relatives about their experience of the care

provided. We spoke with five members of staff including health care assistants, care co-ordinators and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included two people's care records and one person's medication records. We looked at five staff files in relation to recruitment and staff supervision. Copies of the provider's policies and procedures were not reviewed during the inspection because the provider did not have any in place at that time.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We obtained feedback from one external professional who had contact with the service.

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The provider had no effective processes in place to assess, monitor, or improve the safety of the service. For example, the manager told us they reviewed people's daily care logs each month, to identify any risk issues, but we found that not to be the case.
- People's risks were not always assessed, and care plans did not always contain important information. For example, a person had a medical condition which might occasionally require a prescribed medicine to be administered urgently. The care plan did not include specific details of the medicine or clear instructions to staff about when it should be administered. This increased the risk the person may not receive the medicine they required.
- The provider did not gather, or monitor, safety related information to look for themes or trends. The manager told us there had been no safety related incidents, but there was no evidence to support that, nor any process in place to review any incidents which may occur in the future.
- The provider had no health and safety policy or procedures in place. This meant the manager and staff did not have access to clear guidance on safety matters.

Using medicines safely

- The provider's medicines management processes were not safe. For example, there was no guidance in place for staff regarding people's individual prescribed medicines which should be administered 'as and when required'. This increased the risk people may not receive those types of medicines when they needed them.
- Medicines audits were not carried out by the provider. The manager told us they reviewed people's medicine records each month, but we found that not to be the case. This increased the risk medicines errors would go unnoticed and potentially increase the risk of harm to people.
- Staff were not always trained in how to administer medicines safely. The manager told us new staff shadowed existing staff before they could administer prescribed medicines to people. However, there were no records which evidenced medicine training, or observations of staff competence to administer prescribed medicines to people. This increased the risk medicines errors would occur and placed people at increased risk of harm.
- People's care plans did not always include details of all their prescribed medicines. For example, a person's medicine administration record sheet contained details of a medicine which was not listed in the medicines section of their care plan. This was raised with the manager.
- The provider had no medicines policy or procedures in place. This meant the staff and manager had no clear guidance on the safe management of medicines.

Preventing and controlling infection

● The provider had no infection prevention and control policy or procedures in place. This meant the staff and manager had no clear guidance on the prevention of the spread of health infections.

We found no evidence people had been harmed. However, the provider failed to have effective systems and processes in place to ensure care and treatment was provided in a safe way to people. This placed people at increased risk of harm and was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had access to the necessary personal protective equipment (PPE). A staff member told us the provider ensured enough stocks of PPE were available for staff to use when supporting people; in line with Government COVID-19 guidance.

● During the inspection the manager told us they intended to purchase and implement policies from a specialist supplier. Following the inspection, the manager updated one person's medicines care plan in response to the concerns we raised.

Systems and processes to safeguard people from the risk of abuse

● The provider's systems and processes did not protect people from the risk of potential abuse. No effective systems and processes were in place to prevent potential abuse of people who used the service. This increased the risk that people may be harmed.

● The manager did not know how to raise concerns with the local authority safeguarding team. This increased the potential for abuse to go unreported and could delay necessary action being taken to protect people from harm.

● Staff told us they had previously received safeguarding training, but there were no training records available to evidence that, or whether any safeguarding refresher training was required.

● The provider had no safeguarding policy or procedures in place. This meant staff did not have access to clear guidance on safeguarding matters. The manager told us they intended to resolve this by purchasing safeguarding policies and procedures from a specialist supplier.

We found no evidence that people had been harmed. However, the provider failed to ensure effective systems and processes were in place to protect people from abuse and improper treatment. This placed people at increased risk of harm and 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.

Staffing and recruitment

● Staff were not safely recruited. Necessary pre-employment checks were not always carried out by the provider. For example, several staff files did not contain appropriate details of previous employment, criminal record checks, or references. This increased the risk that unsuitable staff might be appointed to work with vulnerable people.

● People were supported by staff who did not always have the necessary safety related training. The provider had no training record system in place. This meant the manager was not aware what training their staff had, and whether additional, or refresher training was required. This increased the risk people would receive poor quality care.

● The provider had no staff recruitment policy or procedures in place. This meant the manager did not have access to clear guidance on safe staff recruitment.

The provider failed to ensure effective recruitment procedures were in place to ensure suitable staff were employed to provide care to vulnerable people. This increased the risk that unsuitable people might be

employed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People did not always have a care plan in place to guide staff on the care and support they needed. For example, we identified a person was supported, for the previous two months, without a care plan in place. This was discussed with the manager who arranged for the person's care plan to be written. The manager evidenced they had done this after the inspection.
- People, and their relatives, told us they were happy with the support the care staff provided to them. One relative told us, "We are very pleased with the staff, they go above and beyond to help [relative]."

Staff support: induction, training, skills and experience

- The provider told us new staff shadowed more experienced staff for several shifts before they could provide support to people by themselves. However, there were no records of those shadowing shifts having taken place, and no details of the experience, competency, or qualifications of the more experienced staff which would enable them to induct new staff.
- Care staff told us they enjoyed their work and found the manager to be supportive. However, the provider had no effective records of staff training, staff induction, or any assessments of staff competency to carry out care tasks; such as moving and handling or the administration of people's prescribed medicines.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's care plans did not always contain details, or contact information, about other agencies and healthcare services who were involved in supporting the person. This meant staff would not always know who to contact if issues arose which needed to be shared with other agencies. This increased the risk of delays in accessing healthcare services and support.

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 Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider told us all the people they supported had the capacity to make their own decisions about the care they received. However, the provider's assessments did not always evidence that. For example, one person's care plan was written with the involvement of their relative rather than the person themselves. There was no information in the care plan which demonstrated if the person had consented to receive care and support, or if a best interest decision had been made on their behalf.
● Some people directed their own support. For example, a person told us how they told the provider's staff what support they needed as and when they needed it. This meant they were able to direct the support themselves and ensured their care needs were met.

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 Good. At this inspection this key question has deteriorated to 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.

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

- The provider was not open and honest. For example, the manager told us they supported two people. When staff told us about a third person the manager admitted they had initially decided not to tell us about that person because they did not have a care plan in place for them.
- The manager told us they employed seven staff. However, we identified there were at least nine staff employed. This was raised with the manager who subsequently told us they had initially attempted to conceal the existence of two staff because they did not have appropriate recruitment records in place for them.
- The service was not well led. The manager was out of touch with what was happening at the service. For example, the manager told us they did not know whether a person had been supported by the service, even though staff told us they had supported the person. Given the small numbers of people the service supported, this demonstrated the manager did not have effective control of how the service operated.
- The manager was not clear about their role and responsibilities. The manager had not ensured there were effective systems in place to ensure the reporting of incidents, risks, issues and concerns was carried out reliably.

Continuous learning and improving care

- The provider's systems for assessing and monitoring the service provided to people were either ineffective or absent. The manager told us they routinely checked the service provided to people and the records of care delivered. We found that not to be the case. This meant opportunities to improve the service were likely to be missed.
- The provider had no policies and procedures in place to guide the manager or the staff. This meant the manager was not able to effectively assess whether the service was operating in line with best practice or not.
- The provider told us there had not been any incidents or issues occur within the service since the last CQC inspection. However, there were no records of any routine monitoring of the service, or any established process by which incidents or issues would be identified by the manager.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The manager did not understand the regulatory requirements. A review of records indicated legally required notifications had not always been submitted to CQC. We are reviewing this and will report on this at our next inspection.
● People's relatives told us the manager of the service was not easy to contact. A relative told us, "I find the manager a bit too laid back about things. I am the one doing all the chasing to get things sorted. I think the manager should be ringing me up on a regular basis, but I don't get any feedback from them about how things are progressing."
● The provider had no policies and procedures in place which explained how they would engage and involve people, fully considering their equality and diversity characteristics. The manager told us they routinely rang the people they supported to obtain feedback. However, we saw no evidence of that and none of the people we spoke to, nor their relatives, mentioned this having taken place.
● A person told us they were involved in directing the care they received. They told us, "The staff are good. They have a care plan folder here, but I usually have to tell them what I need doing." However, the provider had no processes in place which demonstrated how they would support a person who did not have the ability to direct the care staff themselves.

We found no evidence that people had been harmed. However, the provider failed to ensure effective systems and processes were in place to assess, monitor and improve the quality and safety of the services provided to people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The provider failed to have effective systems and processes in place to ensure care and treatment was provided in a safe way to people. This placed people at increased risk of harm and was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure effective systems and processes were in place to protect people from abuse and improper treatment. This placed people at increased risk of harm and 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.

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective systems and processes were in place to assess, monitor and improve the quality and safety of the services provided to people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure effective recruitment procedures were in place to ensure suitable staff were employed to provide care to vulnerable people. This increased the risk that unsuitable people might be employed. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued the provider with a notice of proposal to cancel their registration