Assured Care Southport Limited

Assured Care Southport

Inspection report

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Date of inspection visit:
31 October 2023
03 November 2023
07 November 2023

Date of publication:
12 January 2024

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Assured Care Southport is a domiciliary care agency providing personal care to people living in their own houses, flats and specialist housing. At the time of our inspection the service was supporting 180 people with personal care.

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
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Risk was not appropriately assessed, monitored and mitigated. We found widespread concerns with a lack of information regarding the management of people's individual risks. People were exposed to avoidable risk of harm as systems to ensure the safe and proper management of medicines were inadequate. Staff were administering medicines without any competency checks being completed to ensure they had the skills to do so safely.

The provider failed to ensure the required recruitment checks were carried out on staff which significantly increased the risk of unsuitable staff caring for people.

Safeguarding systems were in place, however, not all staff had received safeguarding training in line with best practice guidance and we were not assured staff had the necessary skills and knowledge to protect people from the risk of abuse.

People were placed at increased risk of harm as staff had not received the required training to meet their needs safely and effectively. Staff who were new to health and social care were not enrolled on The Care Certificate. Relevant training was not provided to ensure staff had the required skills to support people with a learning disability and autistic people in line with right support, right care, right culture guidance.

Care plans did not effectively guide staff on how to meet people's dietary needs, preferences and risks.

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

did not support this practice.

The provider failed to ensure care and treatment was planned for people in a personalised way. There was a lack of person-centred detail in all care plans we reviewed. People's care plans and risk assessments were not always completed, up to date and reflective of their current needs. Accessible formats of communication for people with impaired vision or cognition were not in place to aid their understanding and involvement.

Inadequate governance and quality assurance measures meant people were exposed to unnecessary risk and avoidable harm. The significant shortfalls found with risk assessments, recruitment practices, capacity and consent and person-centred care were not picked up by the registered manager's or provider's monitoring processes. The registered manager failed to have adequate oversight of the running of the service to ensure the required legal regulations were met. Multiple breaches of regulation found at the inspection showed the registered manager and provider lacked a clear understanding of their role and regulatory responsibilities.

People were generally treated with kindness by staff who delivered care. However, the shortfalls found with recruitment, training and care planning did not reflect a caring approach to people's care and support. People told us they were well treated by staff.

Most people and their relatives told us they received support from a consistent staff team who generally arrived to their care calls on time. People told us staff mostly wore PPE and followed good hygiene practices to reduce the risk of infection spread.

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 23 October 2018).

At the last inspection, we recommended the provider reviewed their processes relating to The Mental Capacity Act 2005.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive 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.

Following the inspection, the provider sent us an action plan to demonstrate how they would improve the safety and quality of the service.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, fit and proper persons employed, need for consent, person centred care and good governance 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. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Assured Care Southport

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 3 inspectors and an Expert by Experience who contacted people and their relatives by telephone to gather feedback on their experiences of the care provided. 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, flats and specialist housing.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we received feedback from the local authority regarding difficulty contacting the service. We needed to be sure the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 31 October 2023 and ended on 9 November 2023. We visited the location's office on 31 October, 3 and 7 November 2023.

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. We used all this information to plan our inspection.

The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. Please see the well led section of the report for further details.

During the inspection
We spoke with 10 people who used the service and 5 relatives about their experience of the care provided. We spoke with 16 members of staff including the registered manager, care manager, personnel manager, care co-ordinators and care workers. We reviewed a range of records. This included 15 people's care records and multiple medication records. We looked at 9 staff files in relation to recruitment. We looked at training data and quality assurance records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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

- Risk was not appropriately assessed, monitored and mitigated exposing people to an increased risk of avoidable harm.
- We found widespread concerns with a lack of information regarding the management of people's individual risks. For example, we found no risk assessments were completed for several people in relation to the management of falls, continence, skin integrity, nutrition and hydration and risks associated with long term health conditions.
- Systems in place to manage accidents and incidents were inadequate. Analysis was not undertaken to look for safety related themes and records did not demonstrate lessons had been learnt or outline what action had been taken to reduce the risk of harm. For example, there was no falls management plan or risk assessment in place to guide staff on how to reduce risk for two people who had experienced multiple falls.

The provider failed to assess, monitor and mitigate the risks relating to the health safety and welfare of service users. This was breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not managed safely.
- There were multiple gaps on several people's medication administration records (MAR's) which meant we were not assured people received their medicines as prescribed. This included medicines to treat long term health conditions and medicines to treat acute infections.
- The majority of people's MAR's viewed were poorly completed, illegible and did not contain all relevant information to enable staff to administer medicines safely in line with best practice guidance. Poorly completed medicines records significantly increased the risk of medicines errors.
- Staff had administered medicines without any competency check being completed to ensure they had the skills to do so safely. This included staff who had no previous experience of working in a health and social care setting.
- The systems used to audit the medicines were ineffective. As a result, medicines errors were not identified or addressed.

Systems had not been established to ensure safe and effective administration of medicines. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action following the inspection to improve medication auditing processes.

Staffing and recruitment

● People were exposed to a risk of harm as recruitment procedures were not established and operated effectively .

● The required recruitment checks were not carried out on staff which significantly increased the risk of unsuitable staff caring for people.

● Staff were not always subject to a Disclosure and Barring Service (DBS) check prior to delivering care on a one to one basis in people's homes. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The provider had not considered or mitigated the risk to the people using the service.

Recruitment processes were not robust to ensure staff were suitable to work. This was a breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider committed to improving recruitment practices and gave assurance that checks had been undertaken to ensure all current staff had a valid DBS.

● Monitoring processes were not in place to ensure continual oversight of people's planned care. This increased the risk of missed care calls going undetected and people receiving poor outcomes through not receiving essential care visits.

● Most people and their relatives told us they received support from a consistent staff team who generally arrived to their care calls on time.

Systems and processes to safeguard people from the risk of abuse

● Safeguarding systems were in place. However, we were not assured staff had the necessary skills and knowledge to protect people from the risk of abuse.

● Not all staff had received safeguarding training in line with best practice guidance.

● Staff were unclear on their safeguarding responsibilities and the signs of potential abuse. A staff member told us, "[safeguarding training] needs to be done, they can't define it, staff don't know what safeguarding is."

The failure to ensure staff had received appropriate training for their role is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action during and following the inspection to enrol staff on the relevant training courses to improve their skills and knowledge.

● People told us they felt safe with the staff who supported them.

Preventing and controlling infection

● People told us staff mostly wore PPE and followed good hygiene practices to reduce the risk of infection spread.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People were at an increased risk of harm as staff had not received the required training to meet people's needs safely and effectively.
- For care tasks that required clinical training and oversight, we found no training was provided and no process was in place to ensure the ongoing competency of staff.
- The registered manager lacked an understanding of mandatory training requirements in line with best practice guidance. No staff had not undertaken training in relevant areas such as The Mental Capacity Act 2005, nutrition and hydration and oral health.
- Staff who were new to health and social care were not enrolled onto The Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- Staff were not effectively supervised. Records showed most staff had not received a supervision in the last 11 months.
- People and staff provided negative feedback regarding staff training and skills. A staff member told us, "Training is an issue, I can't be doing with winging it, it shouldn't be the carers responsibility if they haven't had the right training." A person told us, "The carers do not seem to have the skills to do what I need without me having to tell them each time."

The registered manager had failed to ensure staff had received appropriate training for their role. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider sourced clinical training to meet a person's specific needs and enrolled staff on additional training courses.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

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

At the last inspection, we recommended the provider reviewed their processes relating to the MCA and consent. Not enough improvement had been made at this inspection and the provider was in breach of regulations.

● Consent to care and treatment had not been obtained in line with the principles of the MCA placing people at risk of not having their human and legal rights upheld.
● Where there were concerns over a person's ability to consent to specific decisions in respect of their care, no assessment of their capacity to consent had been undertaken.
● Several records showed consent was provided by people's next of kin. However, there was no evidence to show the person lacked capacity to give their own consent.
● Staff responsible for assessing people's capacity to consent lacked an awareness of the principles of the MCA and the appropriate legal processes they should follow.

Processes were not robust enough to ensure people were supported to make decisions about their care and treatment. This is a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet
● Assessments of people's needs and choices had not always been completed placing them at risk of receiving ineffective care.
● There was a lack of information about people's physical and mental health needs and how they were to be met. For example, care plans did not guide staff on people's dietary needs, preferences and risks.
● The provider failed to provide staff with the essential training they needed to ensure care and support for people was provided in line with guidance and the law. For example, relevant training was not provided to ensure staff had the required skills to support people with a learning disability and autistic people in line with right support, right care, right culture guidance.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Processes for monitoring people's health, care and support were ineffective.
● Staff did not always recognise and act on issues identified and escalate when required. For example, there was no evidence to show staff escalated concerns when people's medicines records did not match their current prescribed medicines.
● Care plans did not always include the contact details of other health professionals involved in people's care.

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.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- There was some evidence people were involved in discussions about their care. However, when people lacked the capacity to make decisions about their care, appropriate processes were not always followed to ensure they were involved in the decision-making process.
- Staff described how they maintained people's privacy and dignity. However, there was a lack of information about this in people's care plans.
- Care plans did not evidence how people were supported to maintain their independence. For example, care plans for people who required short term reablement support did not reflect the support they needed to achieve their goals and regain their independence.

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

- People were generally treated with kindness by staff who delivered care. However, the shortfalls found with recruitment, training and care planning did not reflect a caring approach to people's care and support.
- Care plans did not contain enough information to show how people were to be supported with their needs.
- People told us they were well treated by staff. Comments included, "They are kind caring and respectful towards me" and "They are kind, caring, respectful and nothing is a trouble to any of them."

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider failed to ensure a person-centred approach to planning people's care.
- People's care plans and risk assessments were not always completed, up to date and reflective of their current needs.
- People's care plans were not always effectively reviewed to ensure they remained relevant. For example, a person's care plan had not been reviewed since January 2020 and contained very minimal information about their care and support needs and how they were to be met.
- When people had specific health conditions, standardised information was included in care plans. This was not supported by individualised and person-centred care plans detailing how these conditions affect the person.
- Care plans did not always reflect people's choices, likes and dislikes, they were task focused and did not consider people's whole life needs.

The provider failed to operate effective systems to ensure people received person-centred care and treatment. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Records did not always show how people's communication needs were met.
- People's care plans did not always include information to guide staff on how they could support people with their communication needs. For example, a person's care plan stated they had a hearing impairment but there was no additional information to guide staff on the best way to communicate with them.
- Accessible formats of communication for people with impaired vision or cognition were not in place to aid their understanding and involvement.

The provider failed to plan care to meet people's needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● A complaints management system was in place and complaints were responded to. However, complaint records were not well maintained.

● The complaints process was made available to people. People and relatives told us they knew how to make a complaint.

End of life care and support

● The service was not providing end of life care and support at the time of the inspection. However, the provider had failed to ensure staff had the skills to effectively support people if their health needs deteriorated and no training in end-of-life care was provided for staff.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed 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.

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

- Inadequate governance and quality assurance measures meant people were exposed to unnecessary risk and avoidable harm. The provider failed to assess, monitor and mitigate risk relating to the health, safety and well-being of the people using the service.
- The significant shortfalls found with risk assessments, recruitment practices, capacity and consent and person-centred care were not identified by the registered manager's or provider's monitoring processes. This meant these shortfalls had been allowed to continue unchecked and opportunities to improve safety and quality were missed.
- The registered manager failed to implement an effective system to audit medicines and issues found during the inspection had not been identified and addressed. For example, multiple concerns were identified with three people's medicines records. A review of their medicine's records had not been undertaken since they began using the service in 2019.
- Accident and incident processes were inadequate. There was no robust system in place to ensure incidents were recorded and analysed to ensure lessons were learnt to improve people's safety. People experienced recurring incidents with no action taken by the provider to mitigate the known risk.
- Governance arrangements did not promote the provision of high-quality, person-centred care which fully protected people's human rights.

The provider failed to ensure there were effective governance and quality assurance measures in place. This was a breach of regulation 17 (Good Governance) 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 and provider lacked a clear understanding about their role and regulatory responsibilities.
- Multiple breaches of regulation found at this inspection showed the registered manager and provider lacked oversight of the quality and safety of the service.
- The provider failed to learn lessons and respond adequately to serious concerns raised by the CQC. Learning from an inspection of the provider's other location had not been effectively acted upon to improve the quality and safety of the care delivered from this location.
- The registered manager and staff responsible for gaining consent lacked knowledge of the legal processes

to follow under the principles of the MCA 2005.
● The registered manager and staff responsible for enrolling staff on training courses lacked knowledge of best practice guidance relating to mandatory training requirements and best practice guidance for supporting people with a learning disability and autistic people.
● The provider failed to respond to regulatory requests. For example, the required Provider Information Return (PIR) was not submitted to the CQC. This is information providers are required to send us annually with key information about the service.

There was a failure to establish and operate effective systems to ensure compliance with the fundamental standards of care. 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; Working in partnership with others; 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
● There was a lack of engaging, involving and partnership working with others.
● There was a lack of engagement with staff through regular supervisions.
● Reviews were conducted with people using the service to gather their feedback about quality of care. However, records did not always show action had been taken in response to the feedback received.
● The registered manager understood the need to share information about safety related incidents. However, due to gaps found with accident and incident reporting and a lack of registered manager oversight of all incidents, we could not be sure all relevant people had been notified of safety related incidents in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to operate effective systems to ensure people received person-centred care and treatment.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Processes were not robust enough to ensure people were supported to make decisions about their care and treatment.