Your Choice 4 Care Limited

Your Choice 4 Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Your Choice 4 Care is a domiciliary care agency providing personal care and support to people living in their own homes. 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 the inspection, the service was supporting 8 people, 6 of whom were receiving personal care.

People's experience of using this service and what we found
There was an increase in governance and oversight since the last inspection. Governance systems had improved the safety of the service through appropriate inductions, training, competency and spot checks. Risk assessments were in place with care plans having detailed guidance in place to support staff to meet people's needs.

Although there was increased oversight of the service, we continued to identify issues with medicine records, staff recruitment and competency records, late calls and lack of accident and incident monitoring systems. Further work was required to fully address concerns we identified at the last inspection.

Some medicines records were not always accurate. This placed people at risk of having their medicines administered incorrectly.

People were positive about the support from staff and their caring approach. Most people felt communication had improved if staff were going to be late. However, it was acknowledged that care staff were still late. The provider had not taken identified or taken action to address continued late calls.

Improvements had been made to the processes in place for infection prevention and control. Staff had a better understanding and knowledge of government guidance in relation to personal protective equipment.

The registered manager was completing daily checks of records and monitoring records showed shortfalls were being addressed with staff. Staff confirmed any shortfalls regarding logging in, content of daily records and not completing daily notes was followed up with them straight away.

People and staff had completed questionnaires about their experiences of the service. Further collation of responses and analysis had yet to be created.

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 March 2021).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

This service has been in Special Measures since 17 March 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an announced focused inspection of this service on 21 December 2020. Breaches of legal requirements were found. We issued a Warning Notice and placed conditions on the providers registration. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm whether the conditions on registration and the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to requires improvement. 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 Your Choice 4 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 monitor the service 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 medicines and governance systems at this inspection. 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Your Choice 4 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 completed by one inspector and one inspection manager.

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 had a manager registered with the Care Quality Commission. 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.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 28 June 2021 and ended on 16 July 2021. We visited the office location on 28 June 2021.

What we did before the inspection
We looked at information sent to us since the last inspection such as notifications about accidents and safeguarding alerts. 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 sought feedback from the local authority safeguarding and contracting teams. We used all of this information to plan our inspection.

During the inspection
We spoke to four members of care staff and the provider who was also the registered manager. We also spoke with two people who used the service and four of their relatives about their experience of the care provided.

We reviewed a range of records. This included the care records of four people including care plans, risk assessments, medicines records, daily care records and call monitoring records. We looked at two staff files in relation to recruitment, training and their competency in their role. We also reviewed a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We reviewed further information regarding medicines, audits and policies. We also received feedback from two professionals who worked closely with the service.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has now improved 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.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were effectively managed placed people at increased risk of harm. 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.

• Handwritten medicine records were not always checked by another member of staff to ensure they were correct and included all required information. For example, one person's medicine record did not include their address, date of birth and medicine information had not been verified. This meant errors could not be identified and placed the person at risk of having their medicines administered incorrectly.
• Protocols were in place for 'when required' medicines, though they were not always accurate. For example, one person's medicine protocol referred to two different medicines and it was unclear how much medicine should be administered.

The failure to ensure medicines were effectively managed placed people at increased 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.
• Records showed people's medicines were administered as prescribed. Records were fully completed, though not all staff used the required codes consistently. The provider had addressed this issue with staff.
• Staff were trained in administering medicines and their competency assessed to ensure they had the required skills to administer people's medicines safely.

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

At our last inspection the provider had failed to assess, manage and monitor risks which placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this element of regulation 12.

• Risks to people's safety and wellbeing were identified, assessed and strategies put in place to manage the risks. Care plans had been reviewed and included detailed guidance for staff to follow to mitigate the risks, though some care plans did not have correct pictures of the type of hoist people used which could confuse new staff.
• Staff reported concerns to the office, and these were addressed by the care coordinator or registered manager. We received positive feedback from people and staff about the impact the care co-ordinator had on the service due to their responsive approach.
• The registered manager regularly monitored daily records to ensure calls were attended and addressed any shortfalls in records with staff.
• The registered manager assessed staff skills to ensure they were able to support people safely. Staff told us their competency had been assessed in key areas, for example, medicines and moving and handling. Records were in place but were not always fully completed with the assessment date or staff signatures.
• Accidents and incidents had been appropriately responded to. However, there was no effective monitoring system in place to support the provider to identify patterns or trends which made it difficult for the provider to learn lessons and make improvements.
Preventing and controlling infection

At our last inspection the provider had failed to ensure infection control was being effectively managed and, this placed people at increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this element regulation 12.

• Staff were trained in PPE (personal protective equipment) and infection prevention and control. The registered manager completed spot checks and competency assessments to ensure staff had the required skills.
• Staff had sufficient access to PPE and understood how and when to use it. People confirmed staff wore PPE.
• Staff were part of a regular COVID-19 testing programme.
• Risk assessments were in place for people and staff regarding the risks of COVID-19.

Staffing and recruitment

At our last inspection the provider failed to have effective systems in place to ensure the safe and robust recruitment of staff, and that there were sufficient numbers of staff to meet the needs of service users. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

• People did not always receive care at consistent times. However, most people told us this had improved, and communication was better if staff were going to be late. One person told us, "There will be the odd time they're going to be late as sometimes someone might need more support. I wouldn't want them to leave [Person's name] if they were having a problem."
• People were supported by a small, staff team who knew people well and there were enough staff to meet people's needs.
• Recruitment processes had improved. Appropriate recruitment checks were completed to ensure staff

were suitable to work with vulnerable people and risk assessments implemented for staff with limited work experience. Though records were not always accurately completed.
• Induction and training processes were in place to ensure staff had appropriate skills and knowledge for their role. Staff completed mandatory training and shadowed more experienced staff before working alone.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure effective systems were in place to prevent and protect people from abuse and improper treatment. 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

• Staff were trained in safeguarding and understood who to report concerns to internally and to other organisations.
• The provider had raised concerns with the safeguarding team, though records did not always show when this was completed, or the advice received. Monitoring systems required improving to ensure records demonstrated action taken.

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 the last inspection this key question was rated as inadequate. At this inspection this key question has now improved 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; 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; Continuous learning and improving care

At our last inspection the provider had failed to implement and operate effective systems to monitor the quality and safety of the service. 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.

• Sufficient action had not been taken to improve the service by addressing all areas identified at the last inspection.
• Quality assurance systems had not identified or addressed the shortfalls identified during the inspection. These included records relating to medicines, the care people received and staff recruitment and competency.
• An appropriate system to monitor and learn from accidents and incidents was not in place. There was no evidence of analysis or learning from accidents and incidents.
• People continued to receive late care calls and monitoring systems had not resolved this shortfall.

The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service and ensure compliance with the regulations. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Competency and spot checks had been implemented to ensure staff had the required skills for their role. Though records were not always dated or signed by the staff member which meant it was unclear when they were last assessed.

At our last inspection the provider had failed to notify CQC of notifiable incidents that had occurred within the service. This was a breach of regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

• We identified one incident that had not been notified to CQC.

This was a breach of regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009.

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

At our last inspection the provider had failed to promote a positive and open culture which meant good outcomes for people were not achieved. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this element of regulation 17.

• People who used the service and their relatives were positive about the caring approach of staff. One person said, "The staff are very good. Whatever I say to them, they will help me with it."
• Communication from the service had generally improved. Most people told us communication had improved if staff were going to be late, though at times it was difficult to speak to the registered manager. One person said, "Sometimes they're a bit late but I just wait for them or see if I can do anything myself. One of the girls gave me her telephone number and rang me to check I was ok as she was going to be quite late."
• Staff were supported by the registered manager and care coordinator. Staff told us, "It's brilliant. I only have to ring [Registered manager's name] and they'll answer. They'll deal with it straight away."

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

At our last inspection the provider had failed to engage with people and staff in order to drive improvements within the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this element of regulation 17.

• Feedback had been sought from staff and people using the service about their experiences of using the service. The registered manager had reviewed questionnaires which had been completed by staff and had recently sent out questionnaires for people using the service and their relatives to complete. Staff responses were positive.
• Staff meetings were held to ensure they were kept informed about changes to the service and ways of working.

Working in partnership with others
• Staff engaged with and sought advice from healthcare professionals about people's needs to support their wellbeing. Though further work was required to develop positive relationships with key stakeholders.

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 had failed to ensure medicines were effectively managed which placed people at increased risk of harm. 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. 17(1)(2)(a)(b)