Awesome Healthcare Solutions Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Awesome Healthcare Solutions Limited is a domiciliary care service which provides personal care to people living in their own homes. The service mainly provides support to older people, some of whom are living with dementia. At the time of our inspection, the service was providing personal care to 76 people.

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 receive personal care, we also consider any wider social care provided.

People's experience of using this service and what we found
Governance and audit systems were not effective at identifying and reducing risks to people's safety. There was a lack of effective leadership and oversight of the service.

The provider had not identified the shortfalls we found during the inspection process as part of their audits and checks. There were systems in place for managing complaints, safeguarding concerns, accidents and incidents. However, we found these were not robust and feedback from people and relatives on how the provider dealt with complaints and concerns was very poor.

People were not protected from abuse because the systems and processes in place were not robust to keep people safe. Staff we spoke with were aware of their responsibilities to keep people safe Care plans were personalised. However, risk assessments regarding people's health needs, such as epilepsy and diabetes where not sufficient to ensure staff knew how best to support the person. We could not be assured peoples medicines were safely managed.

Feedback from people and relatives was mixed. The main complaint raised by people and their family members was the lateness, shortness of calls and missed care calls. We found from call records and rotas short, late and missed calls had occurred. People felt the communication with the office staff and their responses were unsatisfactory.

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 requires improvement (published 05 March 2020) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
We received concerns in relation to missed and late calls, staff not staying the correct length of time, poor

standards of care. As a result, we undertook a focused inspection to review the key questions of safe and well-led. 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 requires improvement to inadequate based on the findings of this inspection.

We have found evidence the provider needs to make improvements. Please see the safe 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.

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

Enforcement and Recommendations
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 three breaches in relation to safe care and treatment, safeguarding service users from abuse or improper treatment and good governance.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Awesome Healthcare Solutions Limited

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 Act.

Inspection team
This inspection was completed by three inspectors.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with CQC 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 a registered manager in post.

Notice of inspection
This was an unannounced inspection.

Inspection activity started on 29 September 2022 and ended on 03 October 2022. We visited the service's office on 29 September and 3 October 2022.

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 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 nine people who used the service and three relatives about their experience of the care provided. We spoke with registered manager, the nominated individual , two directors, an operations manager and six members of staff. 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 five people's care records and a selection of medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were 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 requires improvement. The rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.
Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider did not ensure the provider's systems and processes to protect people from abuse and improper treatment were operated effectively and consistently. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Safeguarding incidents continued not to be properly managed, recorded and investigated.
- Staff had not always recognised abusive practice. This meant staff and the registered manager had not taken action to safeguard people.
- The provider failed to identify, investigate and report safeguarding concerns to CQC or the local authority. For example, when a relative reported an incident where service users living with dementia were locked out of their home for a long period of time. The provider did not raise it as a safeguarding or reported it to CQC. This incident had put people at increased risk of harm.

The failure to safeguard service users from abuse and improper treatment was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
- People were at potential risk of harm as the provider had not always identified, mitigated or safely managed risks to people. Where risks to people were known, due to their diagnosed health conditions, risk assessments and care plans were not in place to guide staff on how to support people safely.
- A person living with epilepsy had no information in their care plan about how they presented when they had a seizure.
- Another person was assessed as at high risk of falls, however there was no management plan in place to guide staff on how to reduce and safely support this person

Learning lessons when things go wrong
- Incidents had not been consistently recorded or responded to. This meant people using the service were placed at risk from potential further incidents. For example, there was no record staff discussions had taken place to consider the management of incidents and to discuss a change to the support people needed.

The provider failed to ensure care and treatment was provided in a safe way. They did not ensure all risks

relating to the safety and welfare of people using the service were consistently assessed, recorded and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always managed safely. Systems and processes in place did not identify or mitigate the risks to people related to their medicines.

● Medication Administration Records (MARs) were in place, however, staff were not always following this guidance. For example, one person had a medicine prescribed to be given four times a day, but this was recorded as being administered twice daily. This meant the medicine was not being administered as prescribed.

● Where people were prescribed 'as required' medicines (PRN), guidance was not always in place to identify when needed or guide staff on how to support people with this medication .

● Where people required support with applying creams, body maps were not in place in people's homes to guide staff about where and how to apply them.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People and relatives gave us mixed feedback about the care visits. Comments included, " I am happy with the staff that come" and "It's got better, I used to have a lot of missed calls, but I have [staff member] who comes regularly and it's much better." Another person said, "There's just a great deal of disarray and I just don't feel my [relatives] are safe."

● We spoke with the management team about this feedback. The nominated individual insisted that service users had not experienced a missed call, only late calls and call monitoring records were used to check when staff arrived at people's houses to deliver care. We looked at these in response to the feedback we received from people. Some visits were shorter than agreed times and not always on time, although some were also longer where people had stayed additional time to support people. Records showed some people had missed calls.

●The registered manager said there was a '30-minute window', either side of the agreed call time where staff may arrive, although was aware this could also be affected by things such as traffic, or issues at a previous visit. The registered manager said that when staff were late this was logged as a missed call.

● Staff said they felt there were enough staff to care for people safely.

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 with appropriate legal authority. 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.

At our last inspection we made a recommended the provider reviews guidance about the Mental Capacity Act 2005 to ensure their system and processes fully reflect the principles of the MCA. The provider had made some improvements.

● We found the service was working within the principles of the MCA. Records demonstrated people's choices and decisions were respected by staff.
● Care staff demonstrated a good understanding of the MCA. Staff described how they promoted people to be as independent as possible and to make decisions for themselves.

Preventing and controlling infection
● The service had effective systems for managing infection risks including those presented during the COVID-19 pandemic.
● Most people and relatives told us staff were using personal protective equipment (PPE) effectively and safely.

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 requires improvement. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- People did not receive a service that was well-led. This will be the fourth consecutive time the service has been rated requires improvement.
- The registered manager was not in the service on a full-time basis and although contactable by telephone or e-mail they did not have oversight of the quality and safety of the service. The lack of oversight at both location and provider level had contributed to the shortfalls identified. The provider had failed to ensure good quality assurance systems and processes were maintained and this meant the service lacked any sustained and effective improvement.
- The provider had not effectively monitored the service or identified issues that we found at the inspection and people were exposed to unsafe care and treatment.
- Although there was a system to audit aspects of the service, we found these had failed to identify people were not supported safely in a way they chose. They did not identify the concerns with; care plans and risk assessments which required more robust information and guidance to staff, inadequate call times such as short, late and missed calls, poor medication management , a failure to identify and act on safeguarding issues and staffing issues which we identified.
- The management of safety, risk and governance had not been effective. Actions had not been taken by the provider or registered manager to ensure the systems and processes were robust and operated effectively.
- We could not be assured the system used for staff to log in and out of calls and record their notes was safe. Records we reviewed were incomplete or lacked detail and there was little evidence the provider used this information to monitor or improve the service. This meant there the service had no assurances staff attended the calls on time or for the correct length of time.
- Complaints which the provider had recorded did not reflect all of the complaints people and their relatives told us they had raised.
- Services registered with the Care Quality Commission (CQC) are required to notify us of significant events and other incidents that happen in the service, without delay. During this inspection, we found the registered person did not ensure CQC was consistently notified of reportable events such as allegation of abuse within a reasonable time frame. This meant we could not check appropriate action had been taken to ensure people were safe at that time.

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The provider told us they understood the need to work in partnership with and share information with other agencies, including the local authority and community health and social care professionals, to ensure people received joined-up care.

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

● We found from documentation and speaking to people, the service did not always promote a person-centred approach. At the time of the inspection the service did not have an embedded culture that looked to achieve positive outcomes for people.

● Prior to this inspection, we were made aware of concerns people had about the care and support people received. Some of those concerns were confirmed during this inspection.

● Relatives told us communication with the management team was poor and this needed improvement.

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

● People and relatives understood how to contact the office to discuss concerns and had an on-call number they could use when this was closed. However, they found this was often not answered or if it was their concerns were not responded to.

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

● The registered manager told us they understood their responsibility under the duty of candour to act in an open and transparent way in the event things went wrong with the delivery of people's care.

● However, we found they were not fulfilling this obligation with people using the service as they have not acted consistently on complaints and concerns raised.

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 failed to ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure the provider's systems and processes to protect people from abuse and improper treatment were operated effectively and consistently. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.