Choices Healthcare Limited

Choices Healthcare Ltd Suffolk

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Choices Healthcare Ltd Suffolk provides personal care to people who live in their own home. The service supports older people as well as autistic people and people who have a learning disability. The service mainly provides live in care staff to people in their own homes. They also have a supported living service which recently had people living in it but was not active at the time of the inspection.

A supported living service can be shared accommodation or single household properties where people with a learning disability and/or autistic people receive personal care and support to enable them to live as independently as possible. CQC only inspects where people receive a regulated activity of 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 care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked only at people's personal care and support.

At the time of this inspection they were 35 people who received personal care and they were being supported by live in care staff.

People's experience of using this service and what we found
At this inspection we found shortfalls in safeguarding people, recruitment, safe care and treatment and governance and oversight in the service.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. We have made a recommendation the provider fully assesses the care and support provision at Choices Healthcare Ltd Suffolk to embed these principles.

Right Support:
The Mental Capacity Act was not fully understood. We found shortfalls in records and practice, which did not support shared decision making. People were not always supported to have maximum choice and control of their lives. Staff did not consistently 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.

People were not always supported by a staff team who were safely recruited.

Care staff received an induction and ongoing training, they felt supported in their role.

Right Care:
Processes to safeguard people from the risk of abuse were not robust. Not all safeguarding concerns had been escalated properly to CQC. There was mixed feedback regarding communication from the service and with raising a concern.

Care and support was not always person-centred and did not promote people's dignity, privacy and human rights. Risks to people were not always assessed and managed safely.

Right Culture:
The service was not always open and transparent. Systems to monitor the quality and safety of the service were not wholly effective. The provider had not identified the inconsistencies we found during the inspection.

Improvements were needed to the overall governance, management and oversight arrangements of Choices Healthcare Ltd Suffolk.

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 15 June 2018).

Why we inspected
This inspection was prompted in part due to concerns received about staffing, quality of care and safeguarding concerns. A decision was made for us to inspect and examine those risks. We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, recruitment, safeguarding and 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Choices Healthcare Ltd Suffolk

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 team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes through live in care staff. The service is also registered to provide care and support to people living in supported living settings, so that they can live as independently as possible.

People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. There was no one using the supported living service at the time of the inspection.

Registered Manager
This service is required to have a registered manager. The service had a manager registered with the Care Quality Commission. They were also the provider's nominated individual. A nominated individual supervises the management of a regulated activity across an organisation. This meant they were legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

Notice of inspection
This inspection was announced.

We gave the service 48 hours' notice of the inspection. This was because we needed to be sure the provider or management would be in the office to support the inspection.

Inspection activity started on 8 December 2022 when we visited the office location. The Expert by Experience made telephone calls on 14 December 2022. The inspection ended on 21 December 2022 when we gave feedback.

What we did before the inspection
We reviewed information we had received about the service and 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 five people who used the service and seven relatives about their experience of using the service. We spoke with three professionals involved with the service.

We spoke with the registered manager, the provider's director, care manager, three members of staff and two office based staff. We received electronic feedback from seven members of staff.

We reviewed a range of care records for three people. Where applicable this included care and support plans, risk assessments, healthcare information and medication records. We reviewed the recruitment records for four staff members. We also viewed some of the provider's policies and procedures, training data, quality assurance records, management monitoring and oversight records.

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 this key question was rated Good. This has now 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

- People were not always protected from abuse and improper treatment. We received inconsistent feedback about the effectiveness of safeguarding and whistleblowing processes. One relative said, "I reported to the office several times that I was not happy with the live in carer, there were issues with medication, bruising and not following the [care plan]. They were dismissive and I don't think took me seriously. It was very worrying I did not feel [family member] was safe. The live in carer was replaced when [healthcare professionals} got involved but the trust has been damaged."
- Not all staff had confidence in the safeguarding systems in place and a number had raised whistleblowing concerns to CQC. Some staff told us when they previously raised concerns with the management team these had not been taken seriously and they did not have confidence that they had been responded to appropriately.
- Some processes were in place for reporting concerns but not all, for example CQC were not informed of three safeguarding concerns . This is important for oversight of safety. Whilst the management had taken some action to mitigate the safeguarding concerns and alerted the local authority they had not notified CQC.
- During this inspection we made two safeguarding's regarding recruitment and risk management for one person.

The provider had failed to ensure effective processes had been followed to keep people safe. These shortfalls are 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

- There was not a robust system in place to ensure all necessary checks on staff were completed before being employed. The provider did not have oversight of recruitment processes to ensure fit and proper persons were employed. This failure placed vulnerable people at risk of receiving care from staff who were not of good character.
- Disclosure and Barring Service checks were completed for newly employed staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. When the DBS result alerted the manager to a conviction or caution, they had not fully and safely assessed the information to ensure the member of staff was suitable to be employed in the care industry. They had not implemented enough safeguards to protect vulnerable people in their own home.
- We urgently brought these concerns to the attention of the registered manager who took action to address this and ensure people identified were safe. However, the provider's recruitment procedures were

not robust and they had failed to independently identify these significant risks to people's safety.

Robust recruitment processes had not been followed to keep people safe. These shortfalls are a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● Most people and relatives spoke positively about their main live in carer/s and described being treated with kindness and respect. One person said, "My regular [live in carer] is great and knows exactly what they are doing and works with me to make sure I am comfortable." A relative commented, "We have one carer who lives here. They know my [family member] well now and they get on well together."
● Feedback about continuity of care was mixed. Live in care staff worked different patterns, some for several weeks at a time before they took a two week break. Several people and relatives shared examples of poor communication and an unsettling and disruptive service during the changeover period.
● One relative said, "We get fantastic regular carers, but it has fallen apart a couple of times when they have sent people who don't know [family member] as cover. I have a lot of anxiety about it as I never get who I request when [main live in care staff] goes home. The company are OK but I just don't understand why they can't send who I ask for. They tell me who they are sending, and I do understand if a carer can find a regular client, they would want that but it causes me so much anguish. Two carers working opposite one another would be ideal".

Assessing risk, safety monitoring and management
● People were at risk of harm as risks to their health, safety and welfare were not always mitigated and effectively managed.
● Risk to people such as smoking in bed, falls, and pressure ulcers had been identified. However, risk assessments related to these risks were poor and did not contain the required information to keep people safe. This meant they were not adequately protected from harm particularly if staff who were not as familiar with people relied on these documents for guidance.
● People's care records were not always person centred. For example, one person's care plan contained another person's name and other care records contained generic information not relevant to the person whose care plan it was.
● People's care records lacked sufficient detail about how to support them if they were showing signs of distressed behaviours. This meant people were at risk of not being understood and not receiving safe and appropriate care.

Learning lessons when things go wrong
● Safety monitoring was ineffective and did not ensure that lessons were learnt to reduce the risk of reoccurrence.
● There was not an effective system to monitor and analyse accidents and incidents for patterns and trends in place.

Using medicines safely
● Staff responsible for supporting people with their medicines had received training and spot checks were in place to check their competency. Records showed that when errors were made staff were stopped from administering medicines. However, further actions such as additional training, supervision and competency checks were not always documented.
● Although people told us they received their medicines when needed we found unexplained gaps in the Medicine Administration Record (MAR) chart for one person which had not been identified or followed up to ensure medicines were received as prescribed.

● Protocols for medicine to be administered 'as required' were not in place to guide staff. For example, for some people who could become distressed there was no detail of distraction techniques or steps to follow before administering medicine for anxiety. This is important to help people stay well, have a good quality life and stop the over use of psychotropic medicines which are often prescribed to people with a learning disability and or autistic people because their behaviour is seen as challenging.
The shortfalls identified in risk management, oversight and medicines management are a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Preventing and controlling infection
● People and their relatives said staff followed good infection control practice (IPC) in their homes and wore personal protective equipment (PPE) where required. One person said the staff, "Wear gloves and aprons when giving personal care".
● Staff had received infection prevention and control training and additional training relating to COVID-19.

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

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- We were not assured that the staff and management were working in line with the principles of the MCA. There were inconsistencies in understanding and evidencing people's rights under the MCA were being protected. For example, people were presumed to not have capacity and a blanket MCA form was used for assessment.
- An MCA policy and procedure to guide and inform on safe practice was not in place.
- Whilst staff had received training in the MCA there were inconsistencies in their practice.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's medical needs were documented but there were inconsistencies in how associated risks were assessed and managed.
- People's choices as to how they wished their care to be delivered were not consistently recorded in their care plans.
- Improvements were needed to ensure care records were personalised, reflected how people wanted to be supported, took into account what was important to them and reflected people's diverse needs. For example, around people's heritage, beliefs, cultural requirements and lifestyle choices.
- People's care and support plans did not promote strategies to enhance independence and demonstrate evidence of planning and consideration of their longer-term aspirations.

We recommend the provider fully assesses the care and support provision at the service to embed the principles of right support, right care, right culture into care planning and delivery.

Staff support: induction, training, skills and experience

● People were supported by staff who received training and support for their roles. People told us staff had the training and experience needed to deliver effective care. One person said, "The staff are lovely and know what to do to help me." Another said, "I use a [specialist equipment] to get about and my [live in care staff] is at the side of me. I feel very safe knowing they are around, and I can just ask for help." A third person said the live in care staff, "All know how to use [specialist equipment] and I feel safe in it."

● However, relatives feedback was mixed. One relative shared, "I don't think all staff are trained to the same level. I think some of them could do with more support, but I know there's a problem with all companies and trying to recruit good carers." Another relative commented, "Staff seem to know what they are doing. The one we have now is very competent, but the temporary ones are not as aware of the environment and how my [family member] likes things done. All in all, though we are happy".

● Staff were positive about the support they received from the provider including online and practical training they had been given at the start of their employment. One member of live in care staff shared they had completed their refresher training and other commented, " This company always keeps us up to date with courses and training."

● New staff received an induction which included training, assessed shadowing with more experienced colleagues and working on completing 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 form part of a robust induction programme.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported to eat and drink where they required this assistance. This was documented in their care records and provided guidance for staff on how to meet these needs.

● People and relatives told us they were supported to access health care appointments and timely referrals for advice were made when needed. One relative said, "[Family member] became poorly and the live in carer was straight on the phone to the doctor for advice."

● Management and staff told us they worked with other health and social care professionals where concerns were identified, for example with changes in people's care needs, referrals were made to specialist teams such as dieticians and occupational health therapists.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care ;

- Reporting and auditing systems did not support effective oversight, governance and continuous learning in the service. Records did not always show how an incident had been resolved or what actions had been taken to prevent reoccurrence.
- Wider trend analysis which could be used to learn lessons and prevent a similar incident occurring was not evident.
- An effective quality assurance system was not in place to ensure people's care records and staff records were accurate, complete and up to date. This meant people were at risk because staff did not always have the guidance they needed to support people safely.
- The Mental Capacity Act was not fully understood at all levels within the service. We found shortfalls in records and practice that did not support shared decision making. This meant people were not always assisted to have choice and control and their preferences met regarding their care and support.
- Governance and monitoring systems were ineffective and failed to ensure people were safe, their rights were protected and they received quality care and support. The provider had not identified the concerns we found at this inspection, including unsafe care and treatment, and unsafe recruitment.
- Shortfalls with the management and scrutiny arrangements in the service were identified. Following the concerns found at this inspection the provider told us they would make changes to the management structure in the office to improve oversight.

The oversight and governance systems in place were not robust enough to effectively monitor and mitigate risks relating to the health, safety and welfare of people. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

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

- Effective systems to notify CQC of significant events and incidents, in line with their legal requirements and responsibilities as a regulated service provider were not in place. We advised the provider of several incidents that we had not been notified of and they took action to address this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Despite the issues we had identified overall feedback from people and relatives was positive about Choices Healthcare Ltd Suffolk. They told us they were satisfied with the consistent and regular care they received, and most would recommend the service. They said they were regularly asked for their views on their care arrangements and feedback was usually acted on.

● Care staff were complimentary about the provider and the support they received. One member of staff shared, "The management team are always very approachable and supportive, whenever you call them, they are just at the end of the phone to listen and give their support."

● Staff meetings were held so information could be shared, and views and opinions sought. Meeting minutes covered several topics for discussion and staff were free to express opinions.

● The management team shared examples with us of how they worked collaboratively with other professionals. This included professionals who commissioned care from the service and others involved in people's care.

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 Effective safety monitoring and management of risk including lessons learnt was not in place. This put people at risk of avoidable harm.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Effective processes had not been followed to keep people safe.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not in place.

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 17 HSCA RA Regulations 2014 Good governance Quality assurance and governance arrangements were not effective to identify shortfalls and promote improvements.

The enforcement action we took:

Warning Notice served