5 Care Services Ltd

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

Summary of findings

Overall summary

About the service
5 Care Services is a domiciliary care agency registered to provide personal care to people living in their own homes. 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. At the time of the inspection, 123 people were receiving support with personal care. .

People's experience of using this service and what we found
The provider had not ensured risks to people's safety were assessed or managed. There were not enough staff on duty to meet people's needs. The provider had not always protected people from abuse and improper treatment. The provider had not effectively analysed incidents and accidents and had therefore not identified how to help people to reduce the risk of the same thing happening again. The registered manager had not always ensured the safe and proper use of people's medicines.

People's physical, mental health and social needs had not always been holistically assessed to ensure effective outcomes of their care. The provider did not always liaise effectively with other agencies. Staff did not receive regular support.

Some staff told us they did not always have enough time to provide care and support in a compassionate and personal way. Staff knew people well. People we spoke with told us their privacy was respected and their dignity was upheld by care staff.

People were not always given information in a format they could understand. We received mixed views from people and their relatives regarding how the provider deals with complaints.

The provider failed to ensure effective systems and processes were in place to assess, monitor and improve the safety and quality of people's care. The provider failed to act on known risks to service users. Most care staff we spoke with told us there was a poor culture within the service. Team meetings were infrequent and unhelpful. The provider failed to act on feedback from people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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.

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 17 September 2019). The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, and well-led sections of this full report.

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

Enforcement
We have identified breaches in relation to person-centred care, safe care and treatment 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 always effective. Details are in our effective findings below.	**Requires Improvement**
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 always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

5 Care Services 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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 1 inspector 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 houses and flats.

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 24 hours' notice of the inspection. This was because the service is small, and people are often out and we wanted to be sure there would be people at home to speak with us.

Inspection activity started on 20 January 2023 and ended on 27 January 2023. We visited the location's office on 20 January 2023.

What we did before the inspection

We used information gathered as part of monitoring activity that took place on 23 August 2022 to help plan the inspection and inform our judgements. 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. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection. We used all this information to plan our inspection.

During the inspection
We spoke to 8 people who use the service and 7 relatives of people who use the service. We spoke with the registered manager, the director of the service and 9 care staff. We looked at 10 people's care records, 2 staff records, and a range of governance records associated with the monitoring of the service provided.

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. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable

Assessing risk, safety monitoring and management

- The provider did not keep people safe through the assessment and management of risks to people's physical and emotional health and safety.
- During our last inspection we found risks to people's safety were not always assessed or mitigated. At this inspection we found improvements had not been made. For example, one person required the use of a catheter. Staff had not been provided with clear guidance about how to manage the risks associated with its use to prevent the risk of harm.
- One person's care records indicated they had skin damage which was being treated by district nurses. Records contained no other information related to the person's skin damage such as a care plan or risk assessment for staff to follow to prevent further skin deterioration and promote healing.
- Risks to people with swallowing difficulties were not always identified and managed safely. One person was a known risk of choking and required meals prepared in a specific way. There was no specific care plan in place to guide staff when preparing meals. This meant people were at risk of choking.
- Where people had known health conditions, they did not always have care plans and risk assessments in place. For example, one person had been diagnosed with a long-term physical health condition which required support from staff. Records were not in place to guide staff about how to help the person manage the risks associated with this condition.
- The provider had failed to carry out assessments of risks related to people's emotional well-being. For example, one person was known to express their behaviour in a way which may have placed care staff at risk. There was no guidance for staff to follow to know how to support this person safely. This meant staff were not fully aware of the associated risks when working with people who needed support with their mental wellbeing which increased the risk of harm.
- People's risk assessments had not been updated or reviewed following accidents or incidents. For example, one person had a history of falls and had recently fallen in the presence of care staff. No risk assessment or care plan was in place or updated following the incidents to mitigate the risk of reoccurrence.

The provider had failed to ensure risks to people's safety were effectively assessed and managed. This 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.

- Immediately after the inspection the provider acknowledged the seriousness of the concerns and took action to keep people safe. This including making changes to their record keeping and developing an action plan to implement improvements.

Staffing and recruitment
● The provider failed to ensure staff rotas were sufficient to meet people's needs.
● Some people and their relatives told us care staff often arrived late. For example, one person told us, "[Care staff] are too late, I need to go to bed." Another person told us, "I've had to complain as [care staff] are always late." Another person's relative told us they were seeking another care service for their family member as care staff were, "Always late."
● The provider's system which monitored care staff arrival times confirmed staff were often late.
● Staff completed calls over a wide geographical area. The registered manager had not always allocated enough time between calls to ensure people received timely care. This meant people did not always receive the care they required when needed.
● Staff were recruited safely. Pre employment checks were completed including conduct in previous roles, experience and qualifications and Disclosure and Barring Service checks (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● The provider had not always protected people from abuse and improper treatment.
● Some people's relatives told us the inconsistent arrival time of care staff meant people were at risk of neglect. For example, one person's relative told us care staff were often late which led to their relation experiencing periods of incontinence.
● Another person's relative told us their relative often had long gaps between meals as care staff were often late.
● Care staff had received safeguarding training and understood their role in how to keep people safe from abuse.

Learning lessons when things go wrong
● The provider had not effectively analysed incidents and accidents. This meant there was a missed opportunity to improve the service for people.
● For example, when a person fell in the presence of care staff, there was no analysis of the incident or attempts made to mitigate the risk of reoccurrence.
● The registered manager had not analysed the call times of staff even though the issue had been brought to their attention. This meant the care people received was not in line with their needs.

Using medicines safely
● The registered manager had not always ensured the safe and proper use of people's medicines. For example, clear written guidance was not always in place for when to offer people medicines which were prescribed on an 'as and when required' basis (PRN medicine). This meant there was an increased risk of people not receiving their PRN medicines as prescribed.
● Where people were prescribed creams and ointments the registered manager failed to ensure this was done in line with the prescribes instructions. multiple people's medicine records did not include guidance in place for staff to follow when administering topical medication. This meant people were at risk of not receiving their medicine as prescribed.

Preventing and controlling infection
● People and their relatives told us staff wore appropriate personal protective equipment (PPE) when caring for them.
● The registered manager ensured staff received training and were following current government guidance regarding the prevention and control of infection. Care staff were aware of how to wear PPE correctly and

how to safely dispose of it.

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 we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's physical, emotional and social needs had not been holistically assessed to ensure effective outcomes of their care.
- Assessments completed for people were basic and did not always incorporate key information, such as their life history, wishes, preferences or protected characteristics under the Equality Act (2010).
- Where people had known health conditions, assessments were vague and not personalised to the person. For example, 1 person had a number of complex long-term health conditions. Their care records included a generic, medical description of each condition. However, did not provide staff with clear information about the impact of the person's health needs on their care, or care staff's role in helping them to monitor or manage these conditions.
- People's care needs, choices and preferences were not regularly reassessed. For example, 1 person had mental health needs. These had not been assessed in full prior to them receiving care from the service or at any point during their care. This meant people were cared for by staff who did not fully understand their needs.

The failure to assess people's needs is a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider had not always liaised effectively with other agencies, teams and professionals to ensure people's health needs were monitored and met. For example, 1 person had a known skin condition. Their care records indicated district nurses supported them with this condition. However, there was no evidence the provider had liaised with the district nurses to ensure effective care. This meant people were at risk of worsening health conditions.
- Another person had a long-term physical health condition and required support from other health care providers. We saw no evidence the provider had liaised with the providers to promote effective health outcomes for the person.
- Where the provider had referred people to other healthcare providers, there recommendations were not always clearly recorded. For example, 1 person was referred to Speech and language Therapy (SALT). Their care records had not been updated since and therefore did not detail the outcome of the referral or the recommendations made.

● Staff supported people with meal preparation and supported people to eat where needed. Some people and their relatives told us they were often hungry due to the lateness of care staff. One person told us, "If [care staff] are late I can get hungry'. Another person's relative told us they will have to call the office as care staff are late.

Staff support: induction, training, skills and experience
● Most staff told us they did not receive regular supervision. One member of staff told us, "I've not had a supervision since I've been working here." Another member of staff told us when speaking about supervisions, "It's been a while, at least six months." This meant staff did not have the opportunity to discuss their development or training needs.
● In addition, staff told us the quality of supervision was poor with one member of staff telling us, "They are a waste of time." Another member of staff told us, "[Supervisions] used to be great but now they are pointless."
● Most staff had completed mandatory training such as safeguarding, mental capacity and supporting people to move safely.
● New care staff completed an induction programme, key training and shadowed experienced members of staff. New care staff were also required to complete 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

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

● People told us they were asked for their consent before care and support was provided.
● Staff understood the principles of the MCA and how to provide care in line with the MCA.
● The provider understood their responsibilities and was working in line with the principles of the MCA.

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.

Supporting people to express their views and be involved in making decisions about their care
- Some staff told us they did not always have enough time to provide care and support in a compassionate and personal way. Because travel time between care visits was not considered, staff often felt rushed when providing care to people and were not able to spend as much time with people as they wanted to. One member of care staff told us, "I physically don't have enough time to do what I need to do."
- Despite this, most people felt able to express their views and were involved in making decisions about their care. For example, 1 person asked care staff if they could make a particular change to the care provided. They felt care staff listened to the request and ensured it was carried out.

Ensuring people are well treated and supported; respecting equality and diversity
- Although people's care records did not always detail how people wished to be cared for, staff knew people well. Staff we spoke with were able to describe people's care preferences and how they meet them. Staff understood their role and were respectful of people when in their homes.
- All of the people we spoke with told us staff treated them well, with kindness and compassion during care visits. For example, 1 person told us, "I feel so comfortable around them." Another person told us, "I am very happy with the care I get."
- All relatives told us their interactions with care staff had been positive. For example, one person's relative told us, "[Persons relative] feels very comfortable around the carers. They are very caring." Another person's relative told us, "[The carers] are kind and gentle."

Respecting and promoting people's privacy, dignity and independence
- People told us their privacy was respected and their dignity was upheld by care staff.
- Staff we spoke with understood how to ensure people's privacy and dignity was respected. Staff were able to describe how they provided care in such a way.

Requires Improvement

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 requires improvement. This meant people's needs were not always met.

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

- People's care plans were not always person-centred. Care plans did not always include details of people's personal history, individual preferences or interests. This meant people did not always received personalised care.
- People's care plans did not always provide staff with clear guidance on how to meet their individual needs. There was often a lack of information about the management of some people's physical and mental health needs, including long-term conditions such as diabetes or the impact of dementia. For example, the care plans for 1 person with complex physical health needs contained no information for staff about the nature or impact of particular health conditions.
- Another person had complex mental health needs which impacted the person. Care plans had not been implemented to guide staff when caring for the person. This meant people were at risk of being cared for by staff who did not know how to meet their needs.

The provider had failed to assess people's needs and choices. This was a breach of Regulation 9 (Person centred care) 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.

- We found evidence the Accessible Information Standard was not always effectively implemented to ensure people received information in a way they understood.
- One person had a number of health conditions which affected their ability to communicate. Care plans included very little information about the persons communication needs reading, '[Person] is unable to communicate.' There was no other information made available to staff regarding the persons communication needs. This meant people were not able to express their needs to staff who understood how to communicate with them.

Improving care quality in response to complaints or concerns

- The provider had not always ensured complaints were handled in line with their policy. We received mixed views from people and their relatives regarding how the provider deals with complaints.
- For example, when discussing complaints, 1 person told us, "I've complained before, but they don't listen

to you." Another person told us, "I've complained about the time care staff come but [the provider] doesn't listen to me."

● However, another person told us, "[The provider] always listens to me." Another person's relative told us, "I've raises an issue with [registered manager] and found them very helpful.

End of life care and support

● At the time of the inspection no one was receiving end of life care. The provider had a system in place to manage end of life care should they need to.

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; Continuous learning and improving care

- The provider failed to ensure effective systems and processes were in place to assess, monitor and improve the safety and quality of people's care. The provider had failed to make improvements from our last inspection and had not identified the issues we found during this inspection, which included a lack of robust care planning and risk assessment.
- The provider failed to implement an audit schedule or quality assurance policy and procedure, setting out the nature and frequency of audits and checks. We saw multiple examples where planned audits had not been completed.
- There was no monitoring or audits of care call times, medicine administration or people's care plans. . This meant service users were at increased risk of receiving unsafe and poor-quality care.
- The provider failed to implement a system for reporting and recording incidents and accidents. There was no system for the provider to monitor incidents and accidents or analyse associated trends and themes. This meant there was a missed opportunity to improve the service for people and mitigate future risks to their safety.
- The provider failed to act on known risks to service users. Our last inspection report (published 17 September 2019) stated, 'One person did not have a risk assessment in place in relation to catheter care or how staff managed service users' behaviour.' During this inspection, we found the same failings. This meant service users were at risk of receiving consistently unsafe care.

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Following our feedback, the provider agreed to look into these concerns and work with the local authority and clinical commissioning group to improve people's care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Most care staff we spoke with told us there was a poor culture within the service. Staff described having a positive working relationship with their peers but felt this was not the case with the management team. For example, 1 member of care staff described raising an issue affecting their work, with a manager. The

member of staff told us they were not listened to and experienced work-related stress as a consequence.
● Another member of care staff told us about a situation where they had experienced emotional distress as a result of actions taken by a manager. The member of staff told us they were not supported and described the managers interactions as "Rude." Another member of care staff told us they did not feel listened to or supported. The member of staff told us, "Whatever we say, nothing gets done." Some staff told us they would not recommend working for the provider and were actively looking for a new job.
● Staff told us team meetings were infrequent and unhelpful. One member of staff told us team meetings were, "Once in a blue moon." Another member of staff told us, "I've been to one team meetings and was a waste of time. The managers just told us, 'If you don't do what we say, you won't get paid."
● The provider and registered manager had not understood their responsibilities under the duty of candour. For example, the lack of robust incident reporting processes meant the provider was not always aware of events where the local authority and CQC should be notified.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider had sought feedback from people about the service they received. However, they had failed to act on the concerns received. Feedback from people frequently raised concerns regarding the late calls from staff. We saw no evidence the provider had taken any action to address people's concerns. This meant there was a missed opportunity to improve the service.
● The lack of effective quality assurance systems and processes, audits and regular staff meetings meant management and staff did not have a shared understanding of challenges, concerns and risks in relation to people's care.
● We saw little evidence the provider was effectively working in partnership with other agencies to support care provision. For example, where people were working with district nurses, speech and language services and mental health services, there was no evidence of partnership working.

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 9 HSCA RA Regulations 2014 Person-centred care The failure to assess people's needs is a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued the provider with a notice of proposal. This meant the provider had to send us monthly reports outlining the improvements they make.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This 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.

The enforcement action we took:

We issued the provider with a notice of proposal. This meant the provider had to send us monthly reports outlining the improvements they make.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The enforcement action we took:

We issued the provider with a notice of proposal. This meant the provider had to send us monthly reports outlining the improvements they make.