Staff Management Limited

Active Care Group - South Division Care in the Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Active Care Group – South Division care in the home is a domiciliary care agency providing personal care and treatment of disease, disorder or injury to people in their own homes. The service provides specialist support to adults and children who have sustained complex and life changing injuries such as an acquired brain injury. At the time of our inspection there were 86 adults and 32 children using the service, a total of 118 people.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is support with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
We expect health and social care providers to guarantee 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.

Right Support
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People did not have mental capacity assessments or best interest meetings to ensure decisions being made on their behalf were the least restrictive. Staff enabled people to access specialist health and social care support in the
community.

Right Care
People's individual health risks were not always well managed to ensure they received to care and support needed. People were not always supported by staff who had the skills and knowledge needed to meet their needs. People's care plans did not always reflect their range of needs. For example, risk assessments did not always detail enough guidance for staff to support people safely. People's equality and diversity was not considered in their care and support plans. People did not have end of life care plans.

Right Culture
Staff told us they did not always feel supported by senior management at the service. Staff had not always had training in areas which would enable them to support people with all their identified needs. Staff had not completed training in learning disability and/or Autistic people, positive behaviour support or end of life care. People and staff felt communication with the office and senior management was poor.

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 08 August 2018)

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

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 'Active Care Group – South division care in the home' on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, supporting people with decision making under the Mental Capacity Act, person centred care and good governance.

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 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 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Active Care Group - South Division Care in the Home

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 consisted of 2 inspectors, 1 nurse specialist advisor and 2 Experts 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.

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

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

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

Inspection activity started on 19 June 2023 and ended on 27 June 2023. We visited the location's office on 19 June 2023.

What we did before the inspection
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 this information to plan our inspection.

During the inspection
We spoke with 16 people and 4 relatives about their experience of care provided. We spoke with 17 members of staff including the registered manager, recruitment team, quality lead, clinical manager and support workers. We reviewed a range of records including 11 peoples care and support plans and medication records. We also reviewed a range of documents relating to the running of the service, this included audits and 3 staff files.

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

Assessing risk, safety monitoring and management; Using medicines safely

- People had risk assessments in place, however they did not consistently provide clear information and guidance for staff to support people. For example, one person was identified as at risk of choking, however their risk assessment did not contain up to date information around the persons health and the implications it has on their assessed risk of choking.
- Risk assessments did not always have control measures in place to help mitigate the risk. For example, one person had a tracheostomy. A tracheostomy is where a pipe has been surgically inserted into the windpipe to help the person breathe. The risk assessment highlighted that the tracheotomy tube falling out was a risk, however there was no guidance for staff to follow in the event this happened. This could include where the emergency items were kept and who to call for specialist support or assistance.
- People's specific health concerns were not always well monitored. Body maps were not consistently used by staff to monitor skin integrity changes for things such as bruising or cuts. Body maps are a useful tool to assess if a skin concern has deteriorated. The registered manager told us the body maps were not compatible with the system they used for care planning and daily notes, however they were going to look at other ways to include body maps into the records.
- People's medicines were not always well managed. Staff had not consistently and accurately recorded people's medicines when they had or had not administered them. One MAR (medicine administration record) contained a number of gaps without signatures. Staff had not detailed reasons why there were gaps, for example if the medicine had been given by parent. We could not be assured people were always receiving their medicines in line with prescriber guidelines.

The provider had failed to ensure people's health needs were well managed and mitigated and people's medicines were well managed. This is 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 were not always supported by staff who had received relevant training to support their needs. Staff had not completed training in areas including learning disabilities and or Autism. Staff supported people and children where there was an identified need. The registered manager was not following the principles of the Right Support, Right Care, Right culture guidance. The registered manager told us they would be introducing training to staff in these areas.
- Staff had not completed training in positive behaviour support. Some children had been identified as needing support with this and had a positive behaviour support plan in place. Although their regular staff knew them well, they were at risk of not being supported in a way they needed by new or agency staff.

● Staff told us they felt they needed more robust training in a number of different areas in order to care for people safely. One staff member was supporting a person who was nearing the end of their life but they had not had training on how best to support them. The staff member told us they would do their best to support them but feel they need more training and support around this.

The provider had failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The registered manager was not always able to fulfil the staffing needs agreed with care packages. For example, during the first week of June 2023, they were unable to fulfil 5 out of the 7 shifts that were required for one person. People and their relatives told us there was not always enough staff to support them and some care calls would be missed. However, the registered manager told us they were doing everything they could to recruit new staff, such as using social media, conferences and local advertising.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse and harm. The provider had a safeguarding policy in place and the registered manager understood their responsibility to record and report potential safeguarding incidents to the local authority.
● Staff had completed safeguarding training and knew how to apply it to their role. Staff who supported children completed safeguarding for children training.
● People and their relatives told us they felt safe. One person told us, "I feel safe with them [staff]."

Preventing and controlling infection
● People were supported to maintain a clean and hygienic living environment where the support need had been identified in the care plan.
● The provider ensured there was enough personal protective equipment [PPE] available for people and staff. People and relatives told us staff wore PPE, one person told us, "They [staff] wear PPE when its required."

Learning lessons when things go wrong
● The provider had a system in place for staff to report any incidents or near misses. Where incidents had occurred, the registered manager reviewed these and conducted further investigations where required, to reduce the chance of it happening again. For example, there had been an issue with a person's catheter and it was highlighted that staff needed additional training and support in this area.
● However, learning did not always take place when concerns were raised in staff meetings. Care managers and clinical leads held online teams meetings to discuss individual care packages with the assigned staff. We viewed notes for one meeting which discussed one care package, staff had highlighted their concerns around a person health deteriorating and that they didn't have enough knowledge around end of life care to support the person. The notes from the meeting detailed the clinical lead would be there to support when the time came but no other training was offered to staff. Staff told us senior management had not acted on their concerns when they were raised.

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.

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.

● We found the service was not always working within the principles of the MCA. People did not have capacity assessments where it had been identified they may have fluctuating or limited capacity to consent to decisions being made, this included everyday decisions and more complex decisions.
● We were not assured that people were being supported to make decisions on their own, where possible, and that it was the least restrictive option.

The provider failed to ensure they were following legal framework for making particular decisions on behalf of people who may lack capacity. This is a breach of Regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
● People were not always supported by staff who had the experience and knowledge to support them. One person told us, "They didn't know how to use the hoist, so I had to show them." Another person told us, "On occasion carers have had to be replaced while actually on shift, due to not being trained properly."
● Staff told us they felt they needed more support around training and support. One staff member told us, "I could definitely do with a refresher for CPR, as a company they need to do better training." Another staff member told us, "Everything is now online the training, its defiantly not adequate for new staff."
● The registered manager carried out competency assessments for staff. However not all staff received this continuing support. One staff member told us they joined the provider 3-4 years ago and had not had any

competency assessments since their initial mandatory training.

The provider had failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Staff had not always completed a comprehensive assessment of each person's needs. The care plans failed to consider people's protected characteristics under the Equality Act (2010) such as religion, sexuality or gender preference.
● People's care plans were not always updated when their needs had changed, and it was not always clear which version of the care and support plan staff were following. For some people there were a number of versions of the care plans and risk assessments. One staff member told us, "We don't know if there has been any changes, we always ask the parents as the care plans aren't updated."

The provider failed to ensure people's protected characteristics were considered and care plans reflected current needs. This is a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People's support plans did highlight their life history if this was known. Some care plans we viewed also contained long term goals such as making new friends and becoming familiar with their surroundings.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet. People with complex needs received support to eat and drink in a way that met their personal preferences as far as possible. This included nutrition being administered via a PEG. A PEG is a flexible feeding tube placed through the stomach which allowed nutrition and medicines to be put directly into the stomach.
● People gave positive feedback about being support by staff with eating and drinking. One person told us, "When the carers do the cooking they cook for both of us."

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 attend annual health checks, screenings and primary care services where this support need had been identified.
●Staff worked closely with other health professionals including district nurses. One staff member told us, "We have support from the palliative care, district nurses and tissue viability nurses, we are great as a team but Active Care don't have much involvement."

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.

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

- People gave mixed feedback regarding the care and support they received. One person told us, "Some carers like to sit around and do nothing." Another person told us, "Some carers only do the bare minimum." However, we also received positive feedback such as, "I get good care, well looked after." And "The carers are lovely, like family."
- Some people felt staff were not always respectful when in their home. One person told us, "[staff member] didn't respect my property, used my electrical appliances without his agreement. Used a lot of electricity."
- Staff spoke kindly about the people they supported. One person told us, "I love [person] to bits, we work so close with them, supporting them at the end of their life."

Supporting people to express their views and be involved in making decisions about their care

- People's care and support plans didn't outline how to ensure people were involved in making decisions about their care. However, staff were able to give us examples of when they have supported people to make choices.
- One person told us, "The carers support me to go to work and get involve in my hobbies."
- Some people's relatives were involved in their loved ones care and support and helped make decisions on their behalf. Some people the service supported were children and it was detailed if the parents/guardians acted on behalf of the children.

Respecting and promoting people's privacy, dignity and independence

- People told us they felt staff supported their independence. One person told us, "They [carers] help me maintain my independence and live life to the full." Another person told us, "They [carers] treat my home with respect and support me to be as independent as possible."
- Some people's care plans detailed the privacy wishes for relatives within the home for staff that supported young children and babies. The care plan gave guidance where staff could go within the home at night to ensure other siblings or families members were only disturbed if the staff needed additional support. This included things such as having mobile phones on silent during the night.

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.

End of life care and support

- People did not always have end of life care plans in place, even when they were nearing end of life and needed support. The registered manager had not documented any discussions with people and their relatives regarding end-of-life plans, even if the person or relatives felt it was not appropriate at that time, this had not been documented.
- Staff we spoke to were not confident in supported a person who was end of life. They expressed they would do everything they could to meet their needs but they needed training in this area.
- The registered manager told us they do not take on packages where people are already end of life, however due to the complexities of people they support, staff may need to support people and relatives during this time due to health declines. At the time of inspection, the service was supporting someone who was nearing their end of their life.

The provider failed to ensure plans were discussed with people and relatives regarding end of life. This is a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Peoples daily notes were not always person centred. We viewed some people's daily notes and they were tasked based with no narrative. For example, it would detail that a medicine had been given but they did not always include details such as, how the person was feeling that day.
- People and their relatives told us that they were not always involved in the care plan to ensure they received person centred care and support. One relative told us, "I feel it [care plan] needs more details about their requirements, we asked for it to be updated but no idea if it has."

The provider failed to ensure people consistently received person centred care. This is a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The registered manager told us they will always match the gender preference of staff people have.
- People and their relatives told us they were supported by staff to take part in activities if this was an identified need in their care and support plan. One relative told us, "The carers can drive their [persons] care and take them out to do various things."

Improving care quality in response to complaints or concerns

● People, and those important to them, could raise concerns and complaints easily and staff supported them to do so. Some people felt their complaints were handled well but others did not. One person told us, "I had to raise a complaint about a staff member who breached confidentiality, this was handled well by the company [provider]." However, another person told us, "I felt like the carers took liberties, I complained but never got a response."

● The service treated all concerns and complaints seriously, investigated them and learned lessons from the results, sharing the learning with the whole team and the wider service.

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.

● Staff ensured people had access to information in formats they could understand.

● People had communication care plans in place to detail their preferred method of communication and any guidance for staff to aid with communication. For example, one person used Makaton signs and an electronic device. Makaton is a unique language programme that uses symbols, signs and speech to enable people to communicate.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Robust governance systems and processes were not in place to identify issues and ensure there was a system of continuous learning and improving with the care provided.
- Governance processes were not consistently effective to keep people safe and provide good quality care and support. People's risk assessments did not always contain the information needed for staff to support people safely. This included control measures for identified health risks.
- The registered manager had failed to ensure effective systems were in place to address issues around medicines. Medicine audits were carried out by care managers and clinical leads, however these were not always effective at addressing the concerns we found during inspection regarding the recording of medicines.
- The registered manager failed to ensure a robust system was in place to keep people's personal data secure. During inspection we asked for a number of documents relating to a person which included completed daily notes and medicine records. The registered manager was unable to provide this information as they told us this had been lost in the post. The registered manager had not met the requirements of the Data Protection Act 2018.
- The registered manager had not ensured the training systems in place were effective, to enable staff to feel supported and competent in their roles. The registered manager had not provided training in a number of areas such as learning disabilities and end of life care, where there was an identified need. Staff told us the training was not sufficient for them to support people with all of their needs.

The provider had failed to ensure effective and robust governance systems were in place to ensure the health and wellbeing of people who use the service. This is a breach of regulation 17 (governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following inspection, the provider was asked for immediate assurances regarding the concerns we found. The provider sent us an action plan which detailed how they would address the concerns.

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

- The registered manager failed to ensure staff consistently felt supported. The majority of the staff we spoke to felt they weren't supported by senior management. One person told us, "[care manager] is around but we don't get support as staff members, they just let us get on with it."

● The registered manager had not ensured that supervisions were effective to support staff in their role. Staff told us they had completed supervisions with care managers, but they were 'tick box' exercises. One staff member told us, [care manager] pops in but doesn't pay much attention, when I ask for annual leave, they moan."
● Some people told us staff members were not always empowering and supportive. One person told us, "New staff are supposed to phone me first before they come to introduce themselves, but they don't." Another person told us, "I am fortunate I have a regular carer, otherwise its poor."
● People and staff told us staff turnover for the provider was high. A staff member told us, "Massive staff turnover, never knew who you are going to speak to. One person told us, "There is no continuity of staff."
● The registered manager failed to ensure they were following the Right Support, Right Care, Right culture guidance. Training regarding learning disabilities and/or Autistic people was not available to staff. Staff supported young people who had a learning disability and/or Were Autistic people.

The provider failed to ensure people received care that was person centred. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The registered manager failed to ensure people consistently felt engaged with the service. The registered manager told us they communicated with people in a variety of ways such as phone calls and reviews, however these were not effective. People told us that the communication between the office and themselves was poor. People told us they would struggle to contact the office if they had concerns with their care calls. One person told us, "Active care are slow to respond and don't fix things." Another person told us, "If you ring the office, you usually can't speak to anyone."
● The registered manager failed to ensure staff consistently felt engaged with the service. Staff told us, "The communication with staff is appalling." And "I don't hear from anybody if there are changes." And "They [office] never answer my emails regarding work."
● The registered manager supported referrals to health care professionals such as the SALT (speech and language Therapy team), occupational therapists and community nursing teams.

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
● The registered manager understood their legal duty regarding duty of candour. Where incidents had been reported, people's relatives were informed, however people were not always happy with the outcome of their complaint.
● The duty of candour requires providers to be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure plans were discussed with people and relatives regarding end of life.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure they were following legal framework for making particular decisions on behalf of people who may lack capacity.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people's health needs were well managed and mitigated and people's medicines were well managed. The provider had failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective and robust governance systems were in place to ensure the health and wellbeing of people who use the service. The provider failed to ensure people received care that was person centred.

The enforcement action we took:

Warning notice