Generix Associates Limited

Generixcare Luton

Inspection report

Suite 110, Christchurch House
40 Upper George Street
Luton
LU1 2RS

Tel: 01582433754

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Generix Care is a domiciliary care service providing personal care to people in their own homes. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection the service was supporting 60 people, 55 of whom received personal care.

People's experience of using this service and what we found
People and their relatives told us that care staff were sometimes late or did not stay for the agreed amount of time. This led to some people feeling rushed and other people feeling anxious. Some people were put at risk of not receiving safe care as a result of this. For example, some people said they went too long between meals, were left at risk of developing pressure ulcers due to staying in bed for too long or received time critical medicines late.

People also said that some new and agency staff were not well trained and did not have the skills to provide safe care. The provider was aware of this and was taking action to address the induction of new staff and improving access to face to face training for all staff including agency staff.

Although risks to people's health and wellbeing were assessed, guidance to staff about how to support people safely was not detailed enough to ensure consistently safe care. Not all staff understood what a risk assessment was, where to find one or how it related to their work.

Some people were not confident that staff were skilled in administering medicines and gave examples of where errors had been made. Although staff were trained in medicines administration, we found checks made to assess their competence following the training were not always robustly carried out.

Although staff received training in safeguarding people from harm or abuse, staff understanding of types of abuse, signs to look out for and processes for reporting concerns was not strong. The provider had not always reported incidents to the care quality commission in line with regulatory requirements.

Systems to monitor the delivery and quality of care were not always used effectively to identify where improvements to the service were needed. However, where the provider had identified areas for improvement, plans were in progress to take action to address shortfalls.

Measures were in place to manage the risks of COVID-19 including policies and risk assessments. Staff told us they had access to sufficient Personal Protective Equipment (PPE) and had received training on how to keep themselves and others safe from the risks of COVID-19.

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.

The service worked well with other health and social care providers to ensure people received appropriate care, and when shortfalls to this occurred, the provider was proactive in taking swift action to address this.

The registered manager used the views of people who used the service, their relatives and staff to learn and make improvements to the service.

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 17 January 2019)

Why we inspected
We received concerns in relation to care call management, staff skills and practice, risk management in relation to COVID-19 and incident reporting. We undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of the full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to the impact on people of late and shortened care calls, lack of accuracy, detail and awareness of risk assessment and shortfalls in staff skills and knowledge at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Generixcare Luton

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by three inspectors and an expert by experience

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

The service had a manager registered with the Care Quality Commission who was also the provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period of notice for the inspection site visit. This was because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

Inspection activity started on 21 June 2021 and concluded on 13 July 2021. We visited the office location on 21 June 2021 and between 22 June and 13 July we reviewed documentation and made calls to staff, people who use the service and relatives.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed the last inspection report and all the information we

had received about the service since the last inspection. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who use the service and three relatives about their experience of the care provided. We spoke with eight members of care staff, four senior care staff and the provider who was also the registered manager. We reviewed a range of records. This included five people's care records and medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Staffing and recruitment; Assessing risk, safety monitoring and management

- Some people and their relatives told us that care calls were late and that staff were sometimes in a rush to leave. One person said, "The (staff) are rushed. I am pulled about a bit – it gives me some pain." The reported impact of late and rushed calls on other people included being left anxious, being left from 6pm until 11 am without food, being placed at risk of pressure damage from being in bed too long, time critical medication and food being late, and being prevented from getting out of bed because staff did not have time to give this support. Following the inspection we raised our concerns about the impact of late and short calls to the local authority safeguarding team.
- Some staff we spoke with said they did not have enough time and one told us, "We have to cut some of the morning ones (care calls). We make sure everything has been done, and we have to leave, and make up travel time ourselves, otherwise we would run late, and we wouldn't be able to have our own breaks." Records showed some occasions where calls were cut short to as little as five minutes for a call intended to last 30 minutes.
- People told us they were not confident that agency and newer staff had received sufficient training to carry out their role safely. People made comments such as, "The main girls are fabulous, but new carers are not quick enough to get the commode under me when they get me in and out of bed morning and afternoon.." And "The carers fiddle about with the strap (on the hoist)." This resulted in people feeling anxious that staff did not know how to use moving and handling equipment safely.
- All staff received training in moving and handling before working directly with people. However, staff required further guidance on how to put people at ease during these aspects of the care provided to them
- Risks to people's health, safety and well-being were assessed, and measures were put in place to reduce the risks as far as possible. However, in some instances the assessments lacked sufficient detail to guide staff to provide consistent safe care. For example, one person's assessment suggested staff must, 'try to support the person using pillows'. This instruction could mean something different to each member of staff and requires further detail to ensure the person is appropriately assisted. Another risk assessment was inaccurately completed resulting in an incorrect level of risk being identified.
- When asked, some staff were unsure of what was meant by the term 'risk assessment'. They were unsure where to find these assessments and some were not aware of whether or not care staff had access to these. However, there was evidence to show that the provider had included this guidance as part of the induction provided to staff when they started work

People were at risk of harm because care calls were sometimes rushed, late or cut short, and some staff did not have sufficient skills and knowledge to carry out their role safely. Risk assessments were not accurate or sufficiently detailed and some staff did not understand what risk assessment meant. This was a breach of

Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was working to address issues affecting time keeping by providing additional drivers and vehicles to offset traffic and looking at how staff were organised to make sure there were enough staff in each geographical area. However, the lived experience of people, comments from staff and the review of records showed issues were ongoing at the time of the inspection.
● The provider was in the process of setting up a fully equipped training site to improve on face to face training opportunities for staff and had also improved the induction process for new staff. They were extending these training opportunities to agency staff who worked for the service.
● The registered manager ensured that appropriate checks were undertaken to help ensure staff were suitable to work at the service. Criminal record checks and satisfactory references had been obtained for all staff before they worked with people independently.

Using medicines safely
● Not everyone using the service required support to take their medicines. Where they did, some people felt they were not safely supported, and gave examples of errors in medicine administration they had experienced such as missed medicines or medicines administered that were not due to be taken.
● Some staff told us they had concerns about the competence of colleagues in relation to medicines. One member of staff said, 'We do have a lot of clients with medication. Some of the new girls are not doing very well with it.'
● Staff undertook training in how to administer medicines safely and their competency was checked to ensure they understood how to do this. However, we found the records of some checks were not detailed to show how the assessor had come to the judgement that the staff member was competent in this area of their work.
● Where errors in medicines support were reported or identified through auditing processes, appropriate action was taken to seek medical advice and to address the matter with staff concerned.

Systems and processes to safeguard people from the risk of abuse
● Staff had received training about signs of abuse to look out for and how to report any concerns they had. However, some staff we spoke with did not have good understanding of what different types of abuse were or how to report these outside of the service.
● Staff were confident that any concerns they raised to the registered manager would be treated seriously and that action would be taken to keep people safe.

Preventing and controlling infection
● People were protected from the risk of infection because staff had been trained in infection control and followed the current national infection prevention and control guidance.
● Most people told us that care staff wore Personal Protective Equipment (PPE) such as face masks, aprons and gloves during each care visit.
● Some people told us there had been occasions in the past year where staff had not always followed PPE guidance. Records showed that this was managed proactively by the provider who had ensured staff had training and guidance clearly identifying the requirements. We saw that appropriate action was taken to address continued non-compliance with this.
● Staff had received additional training in infection control to help them and people stay safe in relation to the COVID-19 pandemic. Staff also undertook weekly testing and followed self - isolation guidance where necessary.

Learning lessons when things go wrong

- The provider had systems in place to record and respond to incidents, accidents and complaints.
- Any learning from such events was shared through team meetings, supervision meetings and a secure social media group used to keep communication with the team continuous.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has stayed the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Although the systems to monitor the quality of the service had been used to identify some areas of the service requiring improvement, other issues identified at this inspection had not been identified. For example, where risk assessments lacked detail or contained inaccurate calculations.
- The systems to monitor care calls were not used effectively to address late or shortened calls or calls requiring two staff where only one member of staff had attended. The provider told us the current process for monitoring calls was challenging due to the different systems being used and information on each system differing. They said they were looking to increase their administrative team to support this aspect of quality monitoring.
- Competency checks, spot checks and feedback records on the performance of new staff were not always completed in enough detail. They did not show clearly how the judgement was made that the staff member was competent in the area assessed.
- The provider had not always reported notifiable events to the care quality commission as required. We discussed this with the provider who confirmed they would report incidents in accordance with regulatory requirements now they had clarity regarding the expectations.

We found that quality monitoring systems were not always used effectively. There was a lack of effective action taken to address some issues that impacted negatively on the care provided to people. Checks on the competence of staff were not robust and some staff lacked skills and knowledge despite undertaking training in specific areas of their work. There was a failure to report notifiable events to the Care Quality Commission as required. These issues were a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider said they had taken action to address concerns raised by people and their relatives about late and shortened calls. This included reviewing staffing requirements, targeted recruitment and acquiring additional drivers and vehicles to reduce the impact of traffic on timekeeping. However, further improvements were required because people were still experiencing issues relating to care calls that impacted negatively on their care.
- The provider recognised that some senior care staff required further training to support them to complete the supervisory part of their role such as supervising staff, completing assessments and spot checks. This training was in progress at the time of the inspection.

● The provider also confirmed they were working to address shortfalls in staff skills, including new and agency staff. This included setting up a fully equipped training space to deliver face to face training for all staff including agency staff. The induction process for new staff had recently been reviewed and improved to include more shadow shifts before staff worked unsupervised.
● The provider confirmed that they planned to source an audit by an external body, but it had not been organised at the time of the inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives gave mixed feedback about the management of the service. Some people said the service was responsive to any concerns they raised, whereas others felt that nothing was done in response to them raising issues. Records of complaints showed detailed responses given to complaints logged.
● The provider had a clear vision for the service and had developed a service improvement plan to show how this would be achieved. Feedback from people in the form of complaints, compliments, telephone monitoring and surveys was included in the plan to ensure people's views were used to make improvements to the service.
● Staff mostly told us the provider was approachable and quick to respond to any requests for support or advice. They kept staff informed of important information or changes through on-line meetings, telephone calls and through a secure social media group.
● The provider had taken steps to support staff wellbeing during the COVID-19 pandemic. This included initiatives such as promoting healthy eating by providing fresh fruit for all staff every week. They have encouraged staff to be vaccinated through providing financial incentives to staff who receive both doses of the vaccine.

Continuous learning and improving care; 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 provider was open and honest in their approach and was familiar with the duty of candour; they were receptive and open to feedback provided as part of this inspection.
● The provider had created a learning culture, where feedback both negative and positive was used to develop and make improvements to the service.

Working in partnership with others
● The service mostly worked well with other health and social care providers to ensure good outcomes for people using the service. Where this had not happened, the provider took a proactive approach to making improvements once they were made aware of any shortfalls.

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 People were at risk of unsafe care because calls were rushed or shortened and staff did not have sufficient skills and knowledge to care for people safely. Staff did not have good understanding of risk assessments and some risk assessments lack detail or were inaccurate.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found that quality monitoring systems were not always used effectively. There was a lack of effective action taken to address some issues that impacted negatively on the care provided to people. Checks on the competence of staff were not robust and some staff lacked skills and knowledge despite undertaking training in specific areas of their work. There was a failure to report notifiable events to the Care Quality Commission as required. These issues were a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.