Care Label Ltd

SureCare (Reading & East Berkshire)

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
SureCare Reading and East Berkshire is a domiciliary care service providing personal care to 50 people at the time of the inspection. 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. SureCare Reading and East Berkshire provides support to older people, younger adults, people living with dementia, physical disabilities, mental health needs and sensory impairments.

People's experience of using this service and what we found
People did not always experience safe care from the required number of staff, using recognised best practice, exposing the person to risk of significant harm.

The service management was inconsistent and governance of the organisation did not always assure the delivery of high-quality and person-centred care. The provider had not consistently ensured care and treatment was provided safely by staff who had the required competence.

There were enough suitably experienced staff deployed to ensure people did not experience missed calls.However, due to a recent high turnover of staff some people told us they experienced mistimed calls and did not always experience good consistency and continuity of care staff.

Safe recruitment practices were followed and appropriate checks completed to ensure that only suitable staff were employed. Staff understood their responsibilities to protect people from abuse and avoidable harm. People received their medicines safely, as prescribed, from staff who had completed the required training and had their competency assessed to do so. People were supported to maintain standards of cleanliness and hygiene, which reduced the risk of infection. Staff followed the required standards of food safety when preparing and handling food.

The registered manager operated a system of training, competency assessments, supervision and appraisals to develop staff skills and knowledge to support people according to their needs. Staff knew about people's specific dietary requirements and how people wished to be supported to maintain a healthy diet. Staff engaged with other agencies to ensure people had access to the necessary support to meet their healthcare and wellbeing needs. Staff consistently sought people's consent before completing any personal care, were encouraged to make choices themselves and be involved wherever possible in decisions about their care.

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 this practice.

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 1 April 2020).

Why we inspected
We had received concerns in relation to staffing, staff training, unsafe care relating to moving and positioning people and infection prevention and control. As a result, we undertook a focused inspection to review the key questions of safe, effective 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, effective and well-led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for SureCare (Reading & East Berkshire) on our website at www.cqc.org.uk.

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 breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

SureCare (Reading & East Berkshire)

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 one inspector supported by an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the registered manager would be in the office to support the inspection. Inspection activity started on 27 April 2021 and ended on 13 May 2021. We visited the site office on 28 April 2021.

What we did before the inspection
We reviewed other information we had received about the service, including notifications received from the provider. The law requires providers to send us notifications about certain events that happen during the running of a service. We sought feedback from the local authority, community professionals who work with

the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We reviewed the provider's website. 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 used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and four relatives about their experience of the care provided. We spoke with the registered manager, who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the branch manager responsible for the day to day running of the service, two care coordinators and nine staff. We reviewed a range of records including eight people's care records, medicine records and daily notes. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed, including the provider's policies, procedures and quality assurance audits. We reviewed the provider's electronic record system relating to visit allocation, care planning and staff rotas.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three relatives of people who used the service and four community professionals who worked in partnership with the service.

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

● Most people told us there were enough staff to meet their needs safely, although some people told us the consistency of their care staff was not good, particularly during the weekends. One relative told us, "When people get old and confused they need to know who is coming and when they're coming and unfortunately they don't know." Another relative told us, "There's been no missed calls but timing is an issue and there seems to be a rapid turnover of carers [staff]."

● People did not always experience good consistency and continuity of care from regular staff. One family member told us the provider was unable to cover the unexpected absence of care staff over one weekend, although they were informed by the service. One person told us how the provider had forgotten to resume their care provision when they were discharged from hospital. This person told us, "When I came out of hospital they forgot and said I needed two carers [staff]. They forgot me so my daughter in law came to help me." Neither person experienced harm as a result of the service not being able to cover their calls because family members were able to support them.

● People did not always receive their care at the time of their choice. Four relatives told us their loved one had experienced very late calls, with the subsequent visit occurring at the usual time. When asked whether staff arrived on time one relative told us, "Not very often, no. They [staff] don't have a particular time and some days they come at one pm for lunch and then come two hours later for dinner." Another relative told, "We haven't had any missed calls but the times are hit and miss."

● We reviewed the provider's electronic allocation system which ensured all commissioned care was allocated and completed. The management team dynamically monitored this system during the day, which identified when visits had not been completed. When alerted that a call had not been completed the branch manager contacted the relevant staff to ensure they were safe and ascertain the reason for the delay. The office team would then contact people to reassure them and explain the delay. Some people told us they had not always received a call when care staff had been delayed.

● Since January 2021 a number of staff had left the service, which stretched the resilience of staffing. The branch manager was able to demonstrate that minimum staff levels were being met to ensure people were safe.

● At the time of inspection, the provider was actively recruiting more staff to improve continuity and consistency of staffing. The branch manager told us the number of care hours the service provided had recently reduced and they were consolidating the quality of care before taking on further care packages.

Recruitment

● The provider had completed robust pre-employment checks to ensure staff were suitable and had the necessary skills and character to support people living in their own homes. These checks included

prospective staff's conduct in previous care roles, their right to work in the UK, employment references and a Disclosure and Barring Service (DBS) check. The DBS helps to prevent unsuitable staff from working with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
● Most people told us they felt safe with their regular staff.
● People were protected from avoidable harm and discrimination by staff who had completed safeguarding training and understood their responsibilities to protect people from abuse.
● Staff knew the different types of abuse and the provider's and local authority procedures to report concerns. Staff consistently told us they would whistle blow to the local authority safeguarding team or the CQC if they felt the provider had not acted upon their concerns.

Assessing risk, safety monitoring and management
● People's care records included risk assessments, which informed staff how to reduce the risks in people's lives to keep them safe, whilst promoting their independence. This included risks associated with medicines and moving and positioning.
● There were also environmental risk assessments for people's homes, for example; fire risk and trip hazard assessments.
● The service had sought input from external healthcare professionals, where appropriate, with regard to identifying action for staff to take, to safely support people and reduce the risk of harm.

Using medicines safely
● People received their prescribed medicines safely from staff who had completed the required training and had their competency to do so checked every six months by supervisors.
● The provider's policies and procedures gave staff clear guidance about how to manage people's medicines safely. The management team completed regular observations to ensure staff managed medicines in practice, in accordance with their training, current guidance and regulations,
● The branch manager completed regular audits to check staff administered medicines safely and clearly identified any issues or actions to be taken. Staff understood the action to take if a mistake happened, to ensure any potential harm to a person and any future recurrence was minimised.

Preventing and controlling infection
● The provider had regularly updated their policy and procedures in accordance with government guidance during the pandemic and had created a COVID-19 contingency plan.
● Staff had completed infection control training and had access to personal protective equipment (PPE), including aprons, masks and gloves to help reduce cross infection risks.
● People and their relatives told us they felt confident with the infection control practice of staff who consistently wore PPE when delivering their care. One person said, "Yes, I feel protected, they [staff] always wear PPE. I think most of them [staff] have had the jab [vaccination] as well."
● Staff had completed training in relation to safe food preparation and hygiene practices.

Learning lessons when things go wrong
● There was a system in place for recording, reviewing and analysing accidents and incidents. This meant any emerging themes or trends could be identified and lessons learned.
● Learning was shared through communication updates and supervision sessions.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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 did not always experience care, treatment and support in line with legislation, standards and guidance from professional bodies. One person required two staff to move and position them safely. In April 2021, a single staff member visited the person and supported the person to move using a hoist, in contravention of their support plan. During this incident the staff member did not support the person in accordance with their moving and positioning plan and did not use the associated hoisting sling appropriately, exposing the person to risk of significant harm.
- Prior to our inspection, three staff members had raised concerns regarding the quality of their training in relation to moving and positioning people. The branch manager told us that all staff had completed their moving and positioning training, including electronic learning and face to face training. Such training and competency assessments were carried out by an experienced care coordinator or the registered manager. The registered manager was an accredited 'train the trainer', whilst the care coordinator was awaiting such accreditation to enhance their wealth of practical experience in delivering such training. New staff initially shadowed experienced colleagues until they had been assessed to be competent.
- During our inspection most staff told us their training to support people to move safely adequately prepared them to meet the needs of people. However, two staff described the face to face training to be very basic and one staff told us, "I needed more training and was thrown in at the deep end."

Some staff told us they thought the moving and positioning training in their induction could be improved.

The provider's failure to ensure care and treatment was consistently provided in a safe way by staff who had the competence, skills and experience to do so safely, was a breach of regulation 12 (safe care and treatment) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Most people and their relatives told us they felt staff supported them to transfer and transition in accordance with their support plans, for example; when moving from their bed to a wheelchair. One person told us, "They transfer me by hoist. They have good knowledge of the use of the hoist and I feel safe with them.
- Staff told us they had their competency to move and position people assessed during observed spot checks, every three months, which records confirmed.
- Most people and relatives told us, they experienced care in line with their agreed support plan.
- People's assessments and care plans considered all aspects of people's care in line with relevant standards and guidance.
- Care plans clearly detailed people's needs, individual preferences and choices, and how they wished to be

supported. This informed staff how to deliver support to people using best practice to achieve good outcomes, such as working to increase their strength, mobility, nutrition or to maintain healthy skin.

Staff support: induction, training, skills and experience
● The registered manager operated a system of training, competency assessments, supervision and appraisals. This enabled staff to develop and maintain the required skills and knowledge to support people according to their needs.
● Senior staff carried out observations of practice to check staff were supporting people in line with their training and good practice.
● Face to face training had been temporarily suspended in line with COVID-19 guidance but had been reintroduced for moving and handling and some specific medical conditions.
● Records demonstrated that staff training in relation to the provider's mandatory training was up to date.
The provider's induction programme was linked to the Care Certificate. The Care Certificate sets out national outcomes, competencies and standards of care that care workers are expected to achieve. Most staff told us they felt well supported during their induction to the service, with training and shadow shifts with more experienced staff, which prepared them for their role.

Supporting people to eat and drink enough to maintain a balanced diet
● The registered manager placed strong emphasis on the importance of eating and drinking well to maintain people's health and well-being.
● Most people told us they were supported to have enough to eat and drink to remain healthy. One relative told us they had been concerned about their loved one's weight loss during the pandemic, as they had not been able to visit and prepare their meals. The registered manager had referred their concerns to a dietician and arranged for the person's preferred staff to visit to encourage their appetite.
● Staff knew about people's specific diets, personal preferences and how people wished to be supported to eat and drink.
● People's care plans explored whether they had a good appetite, if they had any dietary restrictions or preferences and if they were at risk of malnutrition, weight loss or weight gain.
● Staff followed guidance from relevant professionals to protect people from the risk of poor nutrition, dehydration, swallowing problems and choking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with other agencies and organisations to ensure people had access to the support to meet their healthcare and wellbeing needs.
● People were supported to access healthcare services when they needed additional support. This included support from GP's, community nurses, occupational therapists and dieticians.

● 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 Act 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 staff consistently sought their consent before completing any personal care and were encouraged to make choices themselves and be involved wherever possible in decisions about their care.
● Staff knew about people's individual capacity to make decisions and understood their responsibilities for supporting people to make their own decisions.
● The registered manager understood their responsibilities under the MCA and was aware of the role of the Court of Protection for people living in their own homes.
● Staff told us they had completed training in relation to the MCA, which records confirmed.
● Staff reviewed care plans with people and ensured people agreed with the planned delivery of care before visits commenced.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The leadership, management and governance of the organisation did not always assure the delivery of high-quality and individualised care. The provider had not identified the shortfalls we found during our inspection highlighted in the effective section of this report. During the inspection we found the provider had failed to ensure care and treatment was consistently provided in a safe way by staff who had the skills and competence to do so safely, which was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's failure to effectively ensure compliance with the requirements of the regulations was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had a clear understanding of the regulatory requirements of their role. They ensured we were notified of incidents that could affect the running of the service and people's health and safety.
- Staff received regular updates that were relevant to their role. Most recently they had been receiving updates regarding COVID-19 infection control and the use of PPE. The provider ensured all updates were provided in accordance with current local and national government guidelines and recommendations.

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

- People's experience in relation to the management of the service was mixed. Most people and their relatives expressed confidence that the service was well run. One person told us, "Yes, in general I think it is [well-managed]. They [branch manager] are approachable and fairly responsive."
- However, some people and their relatives thought the management of the service was disorganised. When asked whether the service was well managed, one person told us, "No. They didn't keep to the times I have asked for and every time it's a different carer [staff]. The [staff] don't understand me and I can write a book about the silly things they have done. Some need more training."
- People did not always receive a positive experience when engaging with other office-based staff. Some people and their relatives told us when they contacted the office the quality of the service they received was poor. Some people told us they did not feel listened to and were frustrated at the

inconsistent approach to contacting them when they had raised issues. One relative told us, "You keep raising things but nothing seems to change."
● Most staff told us the branch manager was supportive and listened when they raised concerns. However, some staff told us they did not always feel supported when raising concerns with other office staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were encouraged to express their views and suggestions about the service via face to face meetings, surveys and reviews of their care. This information was used to improve the service. Most people, relatives and staff felt confident their views would be listened to and acted upon.
● Staff meetings were held to keep staff up to date with changes and development within the service. During COVID-19 the levels of staff meetings had reduced however, meetings had been run virtually using technological facilities.
● The service used a secure message platform to effectively share information with staff about people's health needs or changes in their wellbeing.

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 branch manager had a good understanding of their legal responsibilities relating to being honest and open with people when something went wrong.
● Most people told us they did not complain about the service. When they did, this was mainly related to care visit scheduling. Overall people said their complaints had been dealt with promptly.
● People's care records included information on people's complaints, the follow-up actions, and lessons learnt. These had been used to appropriately update the people's care plans.

Continuous learning and improving care
● The branch manager operated a process of continual assessment and quality assurance. Regular spot checks and observations were conducted on staff to ensure they were following their training and meeting people's needs.
● Audits were completed on care plans, medicines, infection control, health and safety and premises checks to monitor the quality of service being provided.

Working in partnership with others
● The branch manager had established working relationships with health and social care professionals. This enabled staff with the required information about how to achieve the best possible outcomes for the people they supported.
● The registered manager had established links with the local provider forums, where they were given opportunities to share best practice.

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 How the regulation was not being met: The provider had failed to ensure care and treatment was consistently provided in a safe way by staff who had the competence, skills and experience to do so safely Regulation 12 (1) (2) (c)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider had failed to establish and operate processes to effectively ensure compliance with the regulations. Regulation17 (1)