Alderson Limited

LIBERTAS

Inspection report

133 Eastgate
Louth
LN11 9QE

Tel: 01507206666
Website: www.libertas.co.uk

Date of inspection visit:
08 November 2023
29 November 2023

Date of publication:
20 December 2023

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
LIBERTAS is a domiciliary care agency providing personal care to people living in their own homes. The service supports older and younger people and people with mental health needs and various other health conditions. The service also provides care and support to people living in two extra care' settings where people's care and housing are provided under separate contractual agreements.

Not everyone who uses the service might receive 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 the service was providing support to 194 people.

People's experience of using this service and what we found
People told us timings of care visits were inconsistent, late or cut short. Some people found this impacted their ability to plan their day which they found frustrating.

People's medicines were mostly managed safely, although sometimes inconsistent care visit times meant medicines were administered later than scheduled, which increased risks to people's health from conditions such as diabetes.

We have made a recommendation to the provider about reviewing care visit times to ensure safe administration of medicines.

Staff received training in safe administration of medicines and had their competency checked by senior staff. Staff worked with local pharmacies and GPs to make sure people had the correct medicine.

Staff had received training in safeguarding and understood how to recognise and report any concerns. Most people told us they felt safe due to knowing the staff and staff treated them with kindness. However, not all people felt this way. Some people had concerns about new staff and agency staff who they felt did not know them or understand how to meet their needs.

People felt confident to speak up where they had concerns but did not always feel their concerns were listened to by the management team.

People's care was regularly reviewed and updated where changes were required. The registered manager conducted various audits to review what was working and what needed to be improved. These were not always effective in identifying the full extent of concerns in relation to care visit times.

Risks to people's health and wellbeing were assessed and staff understood what they were doing and how to identify and report any concerns.

The registered manager ensured all staff had recruitment checks prior to employment to make sure they were suitable for their role and people would be safe.

Staff received full training and induction and took time shadowing other staff. This was so they could get to know people well and how they liked things to be done before providing their care.

People were supported by staff who used effective control measures to reduce the risks of infection and COVID-19. This included washing their hands regularly and followed the latest government guidance.

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.

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 (16 April 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service. We undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for LIBERTAS on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to person centred approaches, quality assurance measures and staff support 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 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

LIBERTAS

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
This inspection was carried out by 1 inspector and 1 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. This service also provides care to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care service.

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 we wanted to be sure the registered manager would be available to support the inspection. Inspection activity started on 8 November 2023.

We visited the location's office on 8 November 2023. We then used remote technology such as email, document sharing, telephone and video calls to speak to people, their relatives, professionals and staff and review various records. We finished the inspection on 29 November 2023, when we met remotely with the registered manager and providers representative to give feedback.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Healthwatch England and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 17 people who used the service and 3 relatives about their experience of the care provided. We spoke with 10 members of staff including the registered manager, training manager, head of operations and care staff. We spoke with two professionals who regularly work with the service.

We reviewed a range of records. This included 6 people's care records and 4 people's medication records. We reviewed the care visit times and related records for 17 people. We looked at 2 staff files and 3 agency staff files in relation to recruitment and staff supervision. We reviewed a variety of records relating to the management of the service, including policies, procedures and audits.

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.

Staffing and recruitment; Using medicines safely

- The provider did not always ensure there were sufficient numbers of suitable staff. Records showed care visits were not always scheduled at agreed times and care visits were cut short. Staff told us they did not receive travel time planned into their rota which had an impact on the times of care visits, often making them late by an hour or more.
- Most people told us they were very unhappy with the inconsistency of care visit times. There was no evidence of missed care visits, but people did tell us some calls were so late they cancelled them and managed their care needs themselves. One person said, "I always feel so rushed when the carers are here as they don't have time, they are keen to get to their next call." A relative told us, "Late visits are frequent. They really do need to make improvements on recruitment and retention of staff. I keep records and my [family member] has had 50 different [staff members] so far this year."
- People were supported to receive their medicines in a way that was not always safe. Inconsistent care visit times sometimes meant people who required their medicines at specific times or with meals were not always able to do so. People had not come to harm, but this placed them at risk of harm.
- People had mixed views about the safe administration of medicines. One person told us, "It is not a very safe service when [staff] arrive very late and you are reliant on them for meals at certain times before you can have your tablets." Another person said, "[Staff] help me with my medication and there have been no errors."

We recommend the provider review all time specific care visits impacting on safe administration of medicines and ensure care visits are scheduled and occurring at the required times.

- Staff were trained in the safe administration of medicines and had their competency and understanding checked by senior staff. Staff understood what to do in the event of an error and how to seek the right medical support for people or report concerns.
- The provider operated safe recruitment processes. They checked the suitability of staff for the role for both permanent and temporary staff members including employment history and a Disclosure and Barring Service (DBS) check. 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

- People were safeguarded from abuse and avoidable harm.
- Staff had received training in abuse awareness and how to report and record concerns. Staff had a good understanding of what signs and symptoms to look out for. They understood how to report to the registered

manager as well as external agencies such as the local authority safeguarding team, CQC and the police.
● People had mixed views on how safe they felt while being supported with their care. One person told us, "I absolutely feel safe with the care staff. I am very happy with the service and they are very kind to me." Another person said, "At the weekend its always agency staff and they are not trained so I have to tell them what to do. Most of the time I feel safe, but I feel a bit worried when a new [staff member] calls that I don't know who has not been trained properly as they don't know what to do."

Learning lessons when things go wrong
● The provider learnt lessons when things had gone wrong.
● Incidents and accidents involving people using the service or staff were recorded and included a session on debrief and lessons learnt. Actions were then linked to an action plan. But this had not improved the quality of care people received. There was a disconnect between the analysis of concerns understood by the registered manager and what people told us they were experiencing. We discussed with the registered manager the need to find new ways of seeking people's views in order to better listen and act on their concerns.
● The registered manager also reviewed complaints to look for ways to improve the service, which were included in the service action plan. Some people did not feel complaints were well managed and told us they had not received feedback or outcomes from their complaints.

Assessing risk, safety monitoring and management
● The provider assessed risks to ensure people were safe. Staff took action to reduce any identified risks.
● Care plans and risk assessments contained guidance for staff about how to safely support people and meet their needs. People with high risk health conditions such as diabetes had been assessed and the care plans contained information for staff about signs indicating a deterioration of their health and what to do.
● People and their relatives were happy with how staff supported them to reduce these risks. A relative told us, "My [family member] is [cared for in bed] but the [staff] do a good job and are very gentle when they move them using a slide sheet to get them washed and changed." Another relative said, "The [staff] monitor my [family member's] skin and apply cream if they have any red marks. They will also phone to request a district nurse visit when they are concerned."

Preventing and controlling infection
● People were protected from the risk of infection as staff were following safe infection prevention and control practices.
● Staff had completed training to understand how to reduce the risk of infection and people told us they followed these processes such as washing their hands, wearing gloves where required and keeping people's homes clean and tidy.

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 Mental Capacity Act (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 found the service was working within the principles of the MCA.
● No-one being supported required a DoLS. However, staff had received training in MCA and had a good understanding of the need to seek people's consent for care and how to respect their decision making.

Requires Improvement

Is the service well-led?

Our findings

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

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

At our previous inspection we found concerns in relation to effective auditing of medicines and a failure to notify CQC of reportable events. At this inspection we found auditing systems were still not effective in identifying and acting on concerns leading to unsafe medicines management. The provider was notifying the relevant authorities of reportable events.

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

- The provider did not always have effective systems to provide person-centred care that achieved good outcomes for people. There was not always a positive an open culture at the service. Staff told us they were unable to meet people's agreed care visit times as they were not scheduled for travel time in between care visits. This had an impact on the day and some staff felt the need to rush the care visit to make up the time elsewhere.
- Almost all of the people and relatives we spoke with told us they experienced inconsistent care visit times due to lateness and/or care visits being cut short. For example, comments included, "The times of calls can be a bit erratic. I feel quite rushed sometimes when staff call." Another person said, "The timings of my calls are constantly changing, I have never been informed or consulted to see if this suits me, it just happens. It is to suit their schedule and not me." A further person told us,, "I am always ready for bed at 8.30pm to 9pm and need a visit at about that time. The past few calls they have not been coming until 10.25pm which is too late for me."
- Some people told us how care visits too late or too early meant they had to do things for themselves and risked falls in the process or neglecting their care. One person told us, "I like my evening call at 7pm, or thereabouts as I like to have dinner before the evening call. [Staff] will arrive early when I am in the middle of a meal. This means I have to rush my meal, which is not good." Another person said, "Calls can be one and half hours late, this is really inconvenient and impacts on the rest of the day. I am supposed to have a shower every day, but this doesn't always happen as the [staff] don't have time."
- People's preferences were not always supported in terms of requesting gender specific staff. One relative told us, "The company will still send male [staff] and my [family member] does not like a male dealing with their intimate care." Reviews resulting in changes to agreed care visit times were not always adhered to. We found the care visits were being scheduled for between 1-2 hours later than agreed and in practice staff arrived at times up to 1 hour later than planned.

Care was not being provided in a person centred way. Care visit times were inconsistent and preferences for

gender specific support or care visit times stated at reviews of care not always adhered to. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider did not have a fully supported management structure. The providers systems did not always effectively monitor the quality of care provided to drive improvement.
- The registered manager had a good understanding of the requirements of their role but the systems were not effective. We identified a number of concerns in relation to care visits, the extent of which had not been identified by the providers own quality assurance measures.
- Following the inspector discussing the concerns, the provider worked with the software company to analyse the issues and try to find solutions. The registered manager reviewed other documents to ascertain where actual errors had occurred. However, this did not account for all scheduled or actual care visit times that were late or where only half the planned visit times had occurred and did not drive improvements in people's experience of the care.
- Staff told us they received supervisions and staff meetings but they felt unsupported and not listened to by the registered manager and office staff. They told us they never got feedback on outcomes from concerns raised and said they felt pressured to cover more care visits than they had capacity to complete which impacted on care visit times or "cutting corners."
- People and relatives were not always involved in the running of the service or in reviews of their care. Their protected characteristics were understood by the management team but people told us when they gave feedback or raised concerns about aspects of their care, they told us they did not receive a response on outcomes. One person told us, "Whenever I speak to the office, I feel as though I am fobbed off and they treat me as though I am an old person." A relative told us, "My [family member] has been having care for several years. They have had no review of their needs. I have had no contact with the office."
- Records showed the registered manager and senior staff recorded and acted on complaints. However, people and relatives felt they were not listened to and were not told outcomes as a result of their feedback. One relative told us, "The interpersonal skills of office staff and the [registered manager] need to be improved and they need to listen to, and deal with complaints."

Systems were not effective in assessing, monitoring and mitigating the risks relating to inconsistent care visit times and the impact this had on people and staff. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection by reviewing the scheduling software and analysing other data to check on care visit times. However, the quality assurance process for this did not include speaking to people to seek their views.

Continuous learning and improving care

- The provider had created a learning culture at the service. However, this had not resulted in people's care improving.
- The registered manager promoted a strong learning ethos and the training manager had created robust training packages for staff, including a scheme for learning coaching skills.
- Whilst there was evidence of learning lessons from incidents with a view of improving care. There was a lack of effective monitoring of fundamental care needs resulting in no consistent improvement to the quality of care people received.

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 understood their responsibilities under the duty of candour.

● The registered manager understood the need to apologise to all relevant people following an incident. They ensured they notified the relevant authorities of notifiable events.

Working in partnership with others

● The provider worked in partnership with others.

● Despite our findings and feedback we received from people, relatives and staff, feedback from professionals was overall positive. One professional gave positive feedback about good communication and partnership working. They also praised the staff training and the registered manager. They included positive feedback they received from people and relatives about the quality of care staff provided.

● We saw evidence of compliments from social workers regarding the quality of care and flexible working approaches to meet people's needs.

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 9 HSCA RA Regulations 2014 Person-centred care Care was not being provided in a person centred way. Care visit times were inconsistent and preferences for gender specific support or care visit times stated at reviews of care not always adhered to.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effective in assessing, monitoring and mitigating the risks relating to inconsistent care visit times and the impact this had on people and staff. This placed people at risk of harm.