Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Care One 2 One

Office A1
23 Bartlett Street
Caerphilly
CF83 1JS

Date Inspection Completed

05/02/2024

About Care One 2 One

Type of care provided	Domiciliary Support Service
Registered Provider	Care One 2 One Ltd
Registered places	0
Language of the service	English
Previous Care Inspectorate Wales inspection	05 July 2023
Does this service promote Welsh language and culture?	The service provides an 'Active Offer' of the Welsh language. It anticipates, identifies and meets the Welsh language and cultural needs of people who use, or may use, the service.

Summary

Inconsistent standards of care mean people are not always safe and healthy. Care workers are kind and treat people with dignity and respect. People mostly receive care in the way they would like to, but some people's care is not delivered in line with their preferences and essential needs. Unsafe medication management and inconsistent timings of care visits put people's emotional and physical wellbeing at risk.

People's personal plans are co-produced with them to include what is important. A more robust approach to risk assessing is needed to ensure risks are mitigated as far as reasonably practicable. Care workers are not safely recruited or sufficiently trained to equip them with the skills and knowledge needed to care for people effectively.

The Responsible Individual (RI) is also the manger for the service, and so is already involved in its day to day running. The RI has failed to take sufficient improvement action since our last inspection and has not undertaken their regulatory duties in line with the Regulations. The RI does not have suitable arrangements in place to assess, monitor, and improve the quality and safety of the service. This means people may not be safe and their wellbeing may be compromised.

Well-being

People mostly receive care in line with their needs and preferences. Care workers are familiar and know people well. People told us care workers are kind and treat them with dignity and respect. People are mostly happy with the care they receive, but some people told us care workers have lots to do in a short time. Some people's individual circumstances are not always considered. Call times are inconsistent and do not always meet preferred times outlined in their personal plans. This has impacted some people negatively, particularly those who rely on care workers for medication administration and personal care. People's feedback should be sought more regularly and used to improve and develop the service.

Personal plans have improved since our last inspection and now focus on what is important to people. This means care workers can access information which helps them deliver care that is meaningful to people. This gives people more control over their day-to-day lives and puts them at the centre of their personal plan. People's language needs and preferences are outlined in line with the Active Offer, so that care workers can tailor their communication to best meet the needs of the person. Although the quality of personal plans has improved, care is not always delivered in line with people's needs identified which has impacted their wellbeing.

The provider uses an electronic care management system so people can access information about their care. This system also allows family members to see when their loved one receives support. One family member told us *"They [the service provider] have embraced technology and I can see in real time the care X has".* This offers relatives assurance that care and support has been delivered. Better oversight of the electronic care management system is needed to ensure people are receiving the best possible care and support.

People are not always safe. A more robust approach to risk assessing is needed to promote people's safety. Risk assessments should be updated in a timely way to accurately reflect people's current needs. Medication management requires improvement to ensure people are administered medication safely to benefit their emotional and physical wellbeing. Care workers are not recruited safely and do not have sufficient skills and knowledge to support people to achieve wellbeing. A lack of specialist training has resulted in some people losing independence, as care workers did not possess the specialist skills necessary to support them safely.

Care and Support

The provider does not have safe and effective standards of care and support that always protects, promotes, and maintains the safety and wellbeing of people. The quality of people's personal plans has improved since our last inspection. Dedicated care co-ordinators review personal plans in a timely way and mostly update them to reflect changing needs. Personal plans are co-produced with people and include what is important to them. However, the provider has failed to consistently deliver care and support in line with people's personal plans to help them achieve wellbeing and keep them safe.

Inconsistent timings of care visits have impacted people's wellbeing. Care visits regularly take place outside of times outlined in people's personal plans. Consistent timings of visits are necessary to many people who rely on care workers for personal care support, medication administration, and meal preparation. People do not always have these basic needs attended to in a safe or dignified way due to visit times being too early or too late.

The provider has unsafe medication management practices which puts people at risk of harm. The provider's medication policy is not robust enough. People are not always administered their medication safely or correctly. Some care workers administer medication without sufficient trained. Time-dependent medication is not consistently administered in line with clinical guidance, meaning people have been administered too much medication in a short space of time. This is often due to inconsistent call times. Care workers do not consistently record missed medication correctly on the electronic administration record, meaning other care workers do not know why medication has not been administered. Clinical advice is not sought for missed medication which puts people's emotional and physical wellbeing at risk. Some people take as required medication, such as pain relief medication, when needed. This medication does not have corresponding protocols, meaning care workers do not have access to guidance on how to safely administer it.

Some people's risk assessments are not robust enough to effectively mitigate risks as far as practicable. People who rely on care workers for mobilising do not have manual handling assessments, meaning care workers do not have accessible guidance on how to safely support them when moving. Risk assessments are not always updated to reflect changing needs and are not consistently reviewed in a timely way. The provider must take immediate action to address this issue.

People offered mixed feedback about the standards of care delivery. One person described the quality of care as *'Absolutely outstanding.'* People described care workers as *'Accommodating'*, *'Helpful'*, and *'Marvellous.'* Some people raised concerns about the timeliness of care visits, and differing standards of care depending on the care worker on shift.

Leadership and Management

The provider has failed to take sufficient action to improve the service since our last inspection. Some internal processes have improved. For example, complaints are dealt with in a more positive and robust way. Overall, more robust governance arrangements are still needed to support a smooth-running service that ensures high quality care and support to people.

The provider has insufficient vetting systems to support the safe recruitment of care workers. Safe and robust recruitment checks are necessary to ensure care workers have the necessary skills, experience, and character to support people. Required information and documentation is not sourced for all care workers before they are employed. This includes proof of identity, working histories, and employment references. Some care workers support people before their Disclosure and Barring Services (DBS) check is returned. This puts people at risk of harm and abuse. The provider must take immediate action to address this issue.

New care workers do not undergo a sufficient induction period. Care workers are not always given sufficient time to complete their induction training and shadow experienced care workers before lone working with people who use the service. Some care workers start lone working before completing all mandatory and specialist training, meaning they do not have the required skills and knowledge to safely support people. Management do not always undertake competency checks for new care workers to evidence they are fit for the role. New care workers do not receive consistent probationary supervision, meaning they may not get sufficient support to help them develop.

The provider does not offer sufficient ongoing support and development opportunities to care workers. This includes providing mandatory and specialist training and consistent staff supervision which enable care workers to safely fulfil the requirements of their roles. Feedback from people included concerns about care workers not being competently trained to undertake specialist care needs. The provider must take immediate action to address this issue.

The RI does not have sufficient systems and processes in place to enable proper oversight of the service. The RI has not undertaken all their regulatory duties. This includes quarterly visits to the service, analysis of complaints and incidents, reviewing people's personal plans, and speaking to people and care workers. Their latest Quality of Care report was not sufficient and did not provide an assessment on the quality of care and support. Feedback and key findings have not been used to improve the service. Without suitable arrangements in place to assess, monitor, and improve the quality and safety of the service, people may not achieve personal outcomes or wellbeing. We expect the RI to take immediate improvement action.

Care workers offered positive feedback about the provider. One care worker described the provider as a *'Brilliant'* place to work and said they feel *'Very supported'* by management.

Summary of Non-Compliance	
Status	**What each means**
New	This non-compliance was identified at this inspection.
Reviewed	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
Not Achieved	Compliance was tested at this inspection and was not achieved.
Achieved	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

Priority Action Notice(s)		
Regulation	Summary	Status
36	The service provider does not have safe and effective standards of care and support which protects, promotes, and maintains the safety and wellbeing of people receiving a service.	New
21	The service provider does not have safe and effective standards of care and support which protects, promotes, and maintains the safety and wellbeing of people receiving a service.	New
66	The Responsible Individual (RI) does not have sufficient systems and processes in place to enable sufficient oversight of the service.	New
35	Safe recruitment practices should be more robust to ensure care workers have the necessary skills, experience, and character to support people	Not Achieved

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

Area(s) for Improvement		
Regulation	Summary	Status
8	More robust internal monitoring and auditing is needed to give assurance on the quality of the service.	Reviewed
41	More robust monitoring of the Electronic Call Monitoring system is required to ensure people are receiving care in-line with their personal plans.	Reviewed

Was this report helpful?

We want to hear your views and experiences of reading our inspection reports. This will help us understand whether our reports provide clear and valuable information to you.

To share your views on our reports please visit the following link to complete a short survey:

- Inspection report survey

If you wish to provide general feedback about a service, please visit our Feedback surveys page.

Date Published 27/03/2024