DCK Care Limited

# DCK Care Ltd

## Inspection report

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31 March 2022
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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
DCK Care Ltd is a domiciliary care agency providing personal care to older and younger adults. The service supported 20 people at the time of the inspection. Not everyone who used the service received personal care. The Care Quality Commission (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. There were 12 people receiving regulated activity at the time of the inspection.

People's experience of using this service and what we found
Medicines were not managed safely. Risks were not managed effectively and placed people at risk of harm. People told us call times and lengths were unpredictable. Staff were not safely recruited. Staff were not suitably trained or supported to effectively carry out their duties. Safeguarding processes in place did not protect people from the risk of abuse and neglect.

Quality monitoring systems were not used effectively in order to improve the quality and safety of care. Known issues were not addressed which meant improvements had not been made. The lack of governance measures in place and poor management oversight meant people were at risk of receiving care which placed them at risk of harm.

The provider had an updated infection control policy in place.

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 12 February 2019).

Why we inspected
We received concerns in relation to staffing, training and management of the service. As a result, 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. The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe 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 DCK Care Ltd 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 monitor the service and will take further action if needed.

We have identified breaches in relation to medicines management, risk management, staffing, recruitment, safeguarding and management of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Details are in our safe findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led.

Details are in our well-led findings below.

# DCK Care Ltd

**Detailed findings**

## Background to this inspection

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

Inspection team
The Inspection was carried out by one inspector and one 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.

Registered Manager.
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 31 March 2022 and ended on 19 April 2022. We visited the location's office on 31 March 2022.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well

and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used all this information to plan our inspection.

During the inspection
On the 31 March 2022 we visited the location's office and spoke with office staff and the registered manager. We reviewed seven staff files in relation to recruitment. We reviewed five peoples' care plans. On 1 April 2022 we spoke with eight people and their relatives about the experience of the care they received from DCK Care Limited. We reviewed electronic documentation in relation to six people's care and the visits they received. We reviewed a range of information requested from the provider, including policies, rotas and training records. We contacted 17 staff to gain feedback about their experience of working at DCK Care Ltd, but none responded. We fed this back to the registered manager who advised they would speak with staff but we still received no response.

Inadequate

# 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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed safely. Medicine records we reviewed did not contain the required information to ensure people received their prescribed medicines safely. Some people were missing medicine administration records entirely. For example, a person living with a radiologically inserted gastrostomy tube (RIG) and received their medicines via this tube did not have a medicine administration record in place.
- We found a number of missing entries on one person's medicine administration record which meant the provider could not be assured the person had received their prescribed medicine.
- The issues found during inspection leave people at risk of not receiving their medicines or receiving their prescribed medicines unsafely.

Assessing risk, safety monitoring and management

- Risks were not assessed, managed or monitored in order to keep people safe from harm.
- Records we reviewed did not contain the risks associated with people's health care needs. For example, a person who lived with chronic obstructive pulmonary disease (COPD) did not have a care plan or risk assessment in place to detail how staff could safely care for them. Furthermore, a person who lived with a radiologically inserted gastrostomy tube (RIG) did not have a care plan or risk assessment in place which adequately directed staff in how to provide safe care. The care plan did not consider any risks associated with a RIG tube. This placed people at risk of harm.
- There was an absence of personal emergency evacuation plans (PEEP) in all the records we reviewed. This placed people at risk of harm if an emergency occurred.

The provider failed to manage medicines safely and ensure risks were managed to keep people safe from harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There were not enough suitably qualified staff to ensure people received care and support which resulted in early, late and missed calls. This placed people at risk of harm.
- People and their relatives told us there was no consistency to call arrival times or lengths. One person's relative we spoke with told us, "They arrive late and rush in and rush out, which means they often don't wash my [relative] properly. When they are really late, my [relative] has often been in a wet pad for between 15 to 18 hours."
- People told us there was no consistency in the staff who supported them, and they had a number of missed calls. Records we reviewed supported this. For example, one person told us, "They don't always stay

for the full amount of time and if they are going to be late, they don't let me know. I am not introduced to new carers; they just turn up."

● Staff were not recruited safely which placed people at risk of receiving care from unsuitable staff.

●Staff files we reviewed did not evidence that all pre-employment checks were being carried out. For example, none of the files we reviewed had two references and many of the files we reviewed had no record of an interview having taken place.

● The provider had employed a number of young workers with no previous health and social care experience without providing them with adequate support. For example, no staff had received a supervision in 2022 prior to our inspection and 39% of staff had not completed their training.

The provider had failed to ensure sufficient suitably qualified and experienced staff were deployed at all times and to recruit staff safely. This was a breach of both regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 and regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● Lesson were not always learnt when things went wrong. Following a safeguarding incident investigated by the local authority not enough action had been taken to ensure the incident was not repeated. No investigation had been completed internally by the registered manager and not all actions instructed by the safeguarding officer had been followed. This meant people were still at risk of receiving unsafe care.

● People we spoke with gave mixed feedback. One person we spoke with told us they didn't always feel safe as they felt staff training was an issue, whereas another person told us despite calls being late when staff did arrive, they felt safe.

● Not all staff had completed training in safeguarding. This meant there was a risk that not all concerns would be reported and investigated by appropriate professionals, placing people at risk of harm. The provider told us during the inspection they would address the issues we found.

The provider failed to ensure systems were in place to ensure people were protected from abuse and neglect. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Preventing and controlling infection

● The provider did not always have robust infection prevention control measures in place to ensure people were protected from the risk of transmissible infections such as COVID-19.

● People and their relatives told us staff mostly wear personal protective equipment (PPE) when they arrived. However, two people we spoke with told us staff have not worn masks recently and they had to request staff put a mask on. The registered manager told us they had started completing spot checks to ensure all staff wore PPE.

● Staff were provided with guidance relating to COVID-19 however training records evidenced not all staff had completed training in infection control.

● The provider had an updated infection control policy to reflect the COVID-19 pandemic.

Inadequate

# Is the service well-led?

## Our findings

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

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

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

- The provider failed to ensure the culture was person centred, open or inclusive. This meant people were at risk of receiving poor care.
- People told us they did not feel the service was person centred and felt staff needed further training in order to improve care. For example, one relative we spoke with told us, "Staff need better training. My [relative] has dementia and at times can be blunt and outspoken. This is how dementia affects them. Recently one staff member walked out on the call because they didn't like how my [relative] was, they have no understanding how dementia effects my [relative]."
- Although people were encouraged to share their views, no action was taken following this information being sought. For example, we found a number of questionnaires in care records, all of which had made concerns relating to call time, length of calls and in some staff performance. No action had been taken and the registered manager had not reviewed these in order to improve the quality of care. This placed people at risk of receiving inconsistent 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; Working in partnership with others

- The registered manager was not aware of their responsibility to investigate, share information and apologise when things went wrong.
- The registered manager demonstrated limited knowledge relating to the duty of candour. For example, we reviewed a safeguarding outcome which demonstrated the provider had failed to meet the needs of a person. We found no evidence of an apology being given to the person.
- A professional we spoke with told us, "I cannot confidently state that the service implement care as planned. In discussing the late/missed calls, [they] consistently said the calls were not late or missed, evidence found did not corroborate this, there were significant delays in information being shared which resulted in a delay in a safeguarding investigation."

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

- The registered manager was not always aware of their regulatory requirements. The registered manager was not fully aware of incidents that they were legally required to inform CQC of. For example, we found incidents of allegations of neglect where the registered manager should have notified us but failed to do so.

● The registered manager did not utilise systems in place to improve the quality of care, known errors and poor practice was not addressed and acted on to reduce the risk to people's health and safety.
● People told us the registered manager was approachable but felt at times they had not taken enough action to address the issues they had raised. For example, people's choice of carer was not always respected as they continued to receive care from staff, they did not want to support them.

Continuous learning and improving care;
● The provider did not utilise quality assurance systems. This meant they did not identify issues to drive service improvement. For example, the provider had not carried out any recent care plan audits.
● There was not an effective audit process in place to identify issues, learn from previous incidents and improvements were not made. For example, there was no audit process in place to identify any of the medicine administration errors we found.

The provider failed to learn, monitor and improve the quality and safety of care. The provider also failed to act on feedback to improve the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they had taken action in order to address the late and missed calls by employing staff who could drive.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider failed to ensure systems and processes were in place to protect people from abuse and improper treatment. |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider failed to ensure medicines were managed safely. The provider also failed to ensure risks relating to peoples needs were managed safely. |

**The enforcement action we took:**

We issued a warning notice.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>he provider had failed to learn, monitor and improve the quality and safety of care. |

**The enforcement action we took:**

We issued a warning notice.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider failed to recruit people safely. |

**The enforcement action we took:**

We issued a warning notice.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure there were enough suitably qualified staff deployed to meet peoples needs. |

**The enforcement action we took:**

We issued a warning notice.