

Absolute Dignity Care

Absolute Dignity Care Ltd

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Absolute Dignity Care Ltd is a domiciliary care agency providing personal care. At the time of our inspection, the agency was supporting 11 people.

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.

People's experience of using this service and what we found

People were at risk of harm as risks were not consistently assessed or mitigated. Systems to protect people from abuse and improper treatment were not effective. Opportunities to learn from adverse incidents had been missed which meant action was not taken to prevent reoccurrence and keep people safe. There was a risk medicines may not be managed safely. People were exposed to the risk of infection. There were not enough staff employed to ensure people's safety and meet their needs and safe recruitment practices were not always followed.

Staff did not have adequate training to provide safe and effective care and support. Issues with staff performance were not always addressed. Care was not always provided in line with national good practice guidelines and there was a risk people may not receive support to maintain their health.

The service was not well led. Governance systems were limited. Issues found during our inspection had not been identified or addressed. Systems to ensure the safety and quality of the service were not used effectively. The registered manager had not addressed known issues and there had been a failure to make improvements in relation to issues found at our previous inspection. People, their relatives and staff had opportunities to provide feedback and shape the development of the service and the provider understood their responsibilities to be open and honest when things went wrong.

Systems did not ensure people's right to privacy was upheld, as steps had not been taken to protect their personal information. There was a risk people may not receive consistent, personalised support. People coming towards the end of their lives had not been given opportunity to think about and plan for their final weeks and days.

People were supported by staff who were kind and caring and they were involved in decisions about their care and support. People were supported to be as independent as possible. 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. People had enough to eat and drink.

Where possible, staff supported people to connect with people who were important to them and their local community. People's complaints and concerns were addressed, however, record keeping in this area was poor.

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 requires improvement (published 5 March 2019).

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement

We have identified breaches in relation to safeguarding, safe care and treatment, staffing levels and staff training, person centred care and governance.

Please see the action we have told the provider to take at the end of this report. 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 continue to monitor information we receive about the service and work with the 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 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 effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-Led findings below.

Absolute Dignity 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 Care Act 2014.

Inspection team

The inspection was carried out by one inspector.

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. 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 it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 11 March 2020 and ended on 13 March 2020. We visited the office location on 11 March 2020 and made calls to people supported by the service, their relatives and staff on 12 and 13 March 2020.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We also sought feedback from 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 used the information the provider sent us in the provider information return. This is information providers are required to send us with key information

about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with five people who used the service and three relatives about their experience of the care provided. We spoke with six members of staff including care workers and the registered manager. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at four 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.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems to protect people from abuse and improper treatment were not effective.
- Safeguarding concerns were not always identified so action was not taken to ensure people's safety and wellbeing. Staff had not attended a person's lunch time care call, staff on a later call had found the person next to an open window, cold and having been incontinent. The person was reliant upon staff to mobilise and attend to all their care needs. This failure to provide support had not been identified by the provider, investigated or referred to the local authority safeguarding team.
- The registered manager had not recognised incidents of a safeguarding nature. Consequently, they had not acted to reduce risk or make referrals to the local authority safeguarding team. Two staff members had a verbal altercation in a person's home, this had resulted in distress to the person. This had not been referred to the local authority safeguarding team.
- Not all staff had the confidence to report concerns. Some staff had concerns about people's welfare but had not reported these to anyone, so no action had been taken.

The provider's failure to protect people from improper treatment and abuse was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People were at risk of harm as risks were not consistently assessed or mitigated and staff did not have sufficient guidance.
- Several people did not have adequate risk assessments in place. This meant levels of risk were not known and there was no guidance for staff on how to reduce risk.
- One person was at increased of developing pressure ulcers. Despite this, there was no skin integrity risk assessment or care plan in place. Records showed they had some pressure damage to their skin.
- Another person was at risk of falls and had suffered injury from previous falls. Despite this, there was no risk assessment in place and no guidance for staff.

Learning lessons when things go wrong

- Opportunities to learn from adverse incidents had been missed.
- The registered manager did not conduct any checks of care records, this meant they had not identified incidents such as missed and late calls, or issues with staff practice. Consequently, no action had been taken to reduce the risk of similar incidents in the future.

Using medicines safely

- There was a risk medicines may not be managed safely.
- Medicines records were not completed accurately as staff did not all know how to use the system. Staff had recorded that they had administered medicine to a person, however, this had not actually been given.
- Some staff had not had any training in the safe administration of medicines and there were no checks on the competency of staff in this area. This increased the risk of unsafe practice or error.
- The registered manager did not complete any checks on the administration of medicines as they did not know how to use the electronic system. This meant medicines errors may not be identified.

Preventing and controlling infection

- People were exposed to the risk of infection.
- At the time of the inspection there was a worldwide outbreak of infection, posing most risk to older people and those with certain health conditions. Most people supported were at increased risk. Despite this, there were no plans in place to reduce risk to people and staff.
- Although staff had access to personal protective equipment at the time of our inspection, no action had been taken to gain adequate supplies of equipment for staff to keep people safe from the spread of infection.

The providers failure to deliver safe care and treatment was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and their relatives told us staff supported them to keep their homes clean and hygienic and commented that staff wore gloves when providing care.

Staffing and recruitment

- There were not enough staff employed to ensure people's safety and meet their needs.
- Although people told us they thought there were enough staff, there had been a recent increase in some people's care calls. There were not enough staff to accommodate this.
- The registered manager told us they were aware that they needed more staff. However, they had not done any formal staff recruitment. They told us they were relying upon 'word of mouth' within the staff team. They had not recruited any new staff at the time of our inspection.
- The issues with staffing meant the registered manager had been undertaking care calls, this had impacted upon the time they effectively manage the service.
- Staff did not have time scheduled to travel between calls, this had resulted in calls being delivered later than planned.

The providers failure to deliver ensure there were enough staff was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were at risk of being supported by unsuitable staff. Pre-employment checks had not always been undertaken to ensure staff were of good character. There was no criminal record check in place for one of the company directors who had access to people's sensitive personal information. References and employment history had not been obtained for all staff, which meant the provider did not have sufficient assurances about staff performance in previous jobs.

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 requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not have adequate training to provide safe and effective care and support.
- Some staff did not have training in key areas. For example, two staff did not have training in medicines management, they were administering medicines. None of the staff had training in supporting people who had a stroke, and only one staff member had training in supporting people with diabetes. Several people supported by the service lived with these conditions.
- The majority of training, including medicines management and first aid, was online with no practical elements. There had been no assessment of staff competency following training. Some staff told us they relied upon training from their previous care roles. This was a concern given that some staff had no background in care.
- Staff performance was not managed effectively. Staff told us they felt supported and had regular supervision. However, when concerns had been raised about the conduct of staff there was no evidence that action was taken to address performance issues.

The providers failure to ensure staff competency was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- At our last inspection we recommended that the service sought advice about moving and handling training. At this inspection we found the provider had ensured staff had practical moving and handling training.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care was not always provided in line with national good practice guidelines.
- People's needs were assessed prior to them receiving support from the service. However, when risks, such as falls, were identified national good practice guidance on risk assessment and reduction were not followed.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- There was a risk people may not receive support to maintain their health.
- Staff did not have access to information about people's health conditions, the impact health conditions had upon them or the signs to look for which would indicate deterioration.
- Changes in people's health needs were not always monitored effectively. For instance, staff noted they

needed to monitor changes in a person's skin condition however, there was no evidence of any monitoring in subsequent records.

- Health professionals, such as nurses and occupational therapists, were involved in people's care. However, their advice was not always documented or made available to staff.

Supporting people to eat and drink enough to maintain a balanced diet

- People had enough to eat and drink.
- People and their families told us staff assisted them to prepare meals and left drinks out for them between visits.
- People told us they were given a choice about what they ate and complimented the quality of food staff prepared. Staff told us they sometimes added 'personal touches' such as picking up lunch for people from the local chip shop.

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 were supported to make choices and their decisions were respected.
- People told us staff consulted with them about their care and sought their consent to any support they provided.
- At the time of inspection, all people supported had capacity to make day to day decisions. Staff had a good understanding of how to support people to make choices and maximise their involvement in decisions.
- Staff understood the MCA and knew how to apply this should someone's capacity to consent change.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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 there was a risk people may not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Systems did not ensure people's right to privacy was upheld.
- Staff accessed care plans on their personal mobile phones. The risks this posed to confidentiality had not been considered and no action had been taken to ensure people's personal information was protected.
- People were not routinely informed about which member of staff they would be supported by. Although people said they felt comfortable with staff, they told us it sometimes caused them anxiety not knowing who was coming to support them.
- People were supported to be as independent as possible. Staff explained how they had encouraged one person to do more and more for themselves. They had grown in confidence and independence so much that they no longer needed support.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported by staff who were kind and caring.
- People's feedback about the approach of staff was unanimously positive. People told us staff were friendly, approachable and patient. One person said, "They treat us very well and take care of everything." Staff told us they cared deeply about the people they supported and said they felt like family. A member of staff commented, "It's a pleasure to support people."
- Staff talked about going the extra mile for people by helping with additional tasks. For example, they had arranged a boiler repair for someone who was unable to do so themselves.

Supporting people to express their views and be involved in making decisions about their care

- People were involved in decisions about their care and support.
- Without exception, people said staff involved them in decisions and listened to their perspective. A relative told us, "Staff support [Name] to make choices."
- Some people did not have any care plans in place, so had not been given formal opportunity to express their views about their care. Despite this, people felt staff knew them well. Staff told us that if a person did not have a care plan, they spent time talking with the person and their family to understand what was important to them.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant there was a risk people's needs may not always be met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- There was a risk people may not receive consistent, personalised support.
- Four of the 11 people supported did not have a care plan in place. This meant there was no written guidance for staff about how to meet their needs. Staff told us they relied up on verbal updates from the registered manager, other staff and the people they were supporting. Although people felt staff knew how to support them, the lack of guidance posed a risk of people receiving inconsistent support.
- Some staff commented that communication and sharing information had recently deteriorated. This meant staff had to spend time chasing up information about changes to people's care needs.
- People coming towards the end of their lives had not been given opportunity to think about and plan for their final weeks and days.
- There were no care plans in place for a person who was coming towards the end of their life. This meant there was no consistent guidance for staff about how to meet their needs and accommodate their preferences at this difficult time.

The providers failure to ensure staff had guidance to enable them to provide person centred care was a breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Since our last inspection the provider had developed guidance for staff about the AIS. Despite a lack of information about people's communication needs in care plans, staff were able to demonstrate how they enabled people to access information.
- Staff had programmed information about call times in to smart speaker to support a person with a visual impairment. They told us this helped reduce their anxiety.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Where possible, staff supported people to connect with people who were important to them and their local community.
- Staff told us they supported people to visit local groups, such as luncheon clubs to help them stay in touch

with people.

- People said staff would often stay and chat with them after they had finished care tasks. This helped them feel less isolated.
- People's families told us staff always kept them informed about changes in people's care and support needs and said that the caring approach of staff extended to them too.

Improving care quality in response to complaints or concerns

- People's complaints and concerns were addressed.
- People and their families felt they could approach staff or the registered manager with any concerns they had.
- People's relatives praised the approach of the registered manager when dealing with concerns. They explained that the registered manager never questioned the validity of the concerns and just got on with sorting things out.
- There was a complaints policy in place, but this had not been followed as complaints and responses were not always recorded. This meant it was not possible for the provider to review and learn from overall themes and patterns of complaints and concerns.

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 now deteriorated 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.

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

- Governance systems were limited. Issues found during our inspection had not been identified or addressed.
- Documentation such as daily records and incident records had not been audited. This meant risks to people's health and safety had not been identified or responded to.
- Systems to ensure the safety and quality of the service were not used effectively. The registered manager did not know how to access some important parts of the electronic care planning system and they had not used key features, like live call tracking, to monitor care delivery. This had a negative impact service quality and people's safety.
- The provider had failed to follow their own policies. For example, staff had raised concerns about professional boundaries. The registered manager had investigated this; however, their response was not in line with the professional boundaries policy. Failure to follow policies sent an inconsistent message to staff and posed a risk to people.
- The provider had failed to maintain secure, accurate and up to date information. Sensitive personal information was not stored securely, and significant gaps in care planning meant they did not hold up to date information about people's needs.

Continuous learning and improving care

- The registered manager had not addressed known issues. They were aware of some issues, such as a lack of care plans for several people. However, they had not rectified this. They told us they knew there were issues with the paperwork, but they did not understand the implications of poor record keeping on actual practice.
- The provider had failed to make improvements in relation to several issues found at our previous inspection. For example, at the last inspection staff competency to administer medicines had not been assessed, this had not been addressed and remained a concern at this inspection.

Working in partnership with others

- The provider had limited links with partner organisations. The provider commissioned business and training support from external agencies. They did not have links with any local or national health and social care forums. This, linked with inadequate quality assurance systems, meant the provider had not kept up to date with good practice and had failed to identify and respond to quality and safety issues.

The providers failure to ensure effective governance and leadership was a breach of regulation 17 (good

governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not notified us of incidents as legally required. A person had sustained a serious injury whilst being supported by staff. This was not reported to us. Failure to notify CQC has a negative impact on our ability to monitor the quality and safety of services.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

- The registered manager and staff shared a core set of values. Staff talked about the service being a 'family affair' and 'going above and beyond' for people. People and their families were, overall, happy with the quality of care they were provided with. One person summed this up, by saying, "I am highly satisfied with the service and the carers."
- Despite this, issues with safety, governance and leadership, referred to in this report meant that people could not consistently be assured of high quality, safe support.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People, their relatives and staff had opportunities to provide feedback and shape the development of the service.
- People and their families had been invited to provide feedback in a recent customer satisfaction survey. The results of this were positive.
- Staff told us they were involved in the running of the service. They talked about teamwork being central to their approach and said that decisions were made between them.
- Meetings were held for staff, these focused on sharing information and addressing issues within the team.

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 duty to inform people when things went wrong. People's relatives told us the registered manager was very open and honest and always apologised for any wrong doing.

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 18 Registration Regulations 2009 Notifications of other incidents We were not notified of a serious injury. Regulation 18(2)