A Star Complex Care Limited

A Star Complex Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
A Star Complex Care provides personal care and support to people living in their own homes. 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; at the time of our inspection the service provided personal care for 24 people.

People's experience of using this service and what we found
This service was not safe. The service was very shorted staffed, there were not enough staff to meet people's needs safely; and this made the service unreliable. Staff had not been recruited safely. This meant that the provider could not be sure that care staff providing personal care for people in their own homes were safe to do so. Also, the assessing of risks and the management of risk in the provision of people's care was inadequate.

By providing an unreliable service, not recruiting staff safely and failing to adequately assess risks people were exposed to an increased risk of avoidable harm.

Most people told us that care staff were nice in their manner towards them; however, the unreliability of the service had a negative impact on them taking their medication on time, eating regular meals and effected their wellbeing. One person told us, "They never tell me they are running late… waiting for over hour and half, it gets a bit much. There is only one number to call and no one answers. They always say we are on the way... you just sit here and wait." One person's relative told us, "The times are out of sync, everything is out sync. [Name] gets angry and upset… and it has [a] big impact and ongoing cycle."

The registered manager and nominated individual told us that because they were short of staff they spent time completing people's care calls. They had been doing this for some time been doing this for between 70 and 90 hours per week. This left them no capacity to assess the service and plan how they were going to improve the safety and quality of the service they were providing. They were not taking enough action to reduce the risks identified from being short staffed.

People were not supported to have maximum choice and control of their lives. The provider was not able to demonstrate that people had been involved in planning their care and were supported in making decisions about their care. People told us that they were not listened to when they raised a concern.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 06/08/2018 and this is the first inspection.

Why we inspected

This inspection was prompted in part due to concerns received about the provider having unsafe recruitment practices and not ensuring that staff had appropriate training, induction and skills necessary for their role. A decision was made for us to inspect and examine those risks.

We found evidence that the provider needed to make improvements. For more information please see the detailed information in the full version of this report. We asked the provider to produce an urgent action plan to demonstrate what actions they would take to ensure people were safe. During the inspection process the provider decided to close the service and to stop providing any regulated activity.

Enforcement
We have identified breaches in relation to regulations on; safe care and treatment, fit and proper persons employed, staffing, receiving and acting on complaints, person-centred care and good governance. You can see what action we have asked the provider to take at the end of this full report.

Follow up
This service was closed by the provider during the inspection process. We are continuing to monitor A Star Complex Care to make sure that it is no longer providing a regulated activity for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

A Star Complex Care

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 conducted by an inspector and an assistant inspector.

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 a short period of 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 10 July 2019 and ended on 24 July 2019. We visited the office location on 10 July 2019.

What we did before inspection
We reviewed information we had received about the service since it was registered and we sought feedback from the local authority who work with the service. This information helps support our inspections and we used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager and the nominated individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also

spoke with four people and three people's family members.

We did not have the opportunity to speak with any care staff.

After the inspection
We asked the provider for an action plan to tell us what immediate action they were going to take to ensure people were safe. Shortly after this request the provider told us that they were going to close the service and stop providing any regulated activity. We are continuing to monitor A Star Complex Care to make sure that it is no longer providing a regulated activity for people.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- The regulations clearly state what information providers need to consider and what checks need to take place to help ensure new staff are safe to provide personal care for people. The registered manager was aware of these requirements; however, these checks had not been fully completed for any staff member.
- The provider and registered manager were not able to provide evidence that they had applied for a Disclosure and Barring Service (DBS) check or had checked the status of a DBS for any staff member. The DBS completes background checks on applicants which usually help the registered manager make decisions on people's suitability to work with people who may be vulnerable due their circumstances and is a legal requirement.
- The inadequate system for safely recruiting new care staff meant that the registered manager and the provider could not be sure that care staff providing personal care for people in their own homes were safe to do so. Not completing these checks exposed people to an increased risk of harm.

Staff pre-employment checks were inadequate. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service was very short staffed, there were not enough staff to meet people's needs safely.
- Most people told us that the service was unreliable. One person said, "[I] wasn't satisfied and I have been let down quite a few times, some days no one turned up which is disgraceful." Another person told us that they have had to complain to staff for missing some of their visits. A third person said, "I've rang them 80 odd times, [asking] where people are and so forth."

There were not enough staff to meet people's needs safely. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- The assessing of risks and the management of risk in the provision of people's care was inadequate.
- The care file for one person contained no risk assessment. For other people there was a tick box risk assessment; when risks had been highlighted there was no guidance for staff on how to reduce these risks for the person.
- The registered manager and nominated individual did not use the system available to them to monitor the reliability and safety of the service. The system showed missed calls, very late calls and very short calls, for which an explanation had not been explored.

Using medicines safely

● The administration of people's medication was not consistently safe.
● The registered manager told us that they provided medication administration training for staff and after training checked the competencies of them to administer medication safely. However, when asked they told us that they made no records of this training or of the checks of staff competencies.
● The unreliability of the service had an impact on people being supported to take their medication on time. One person told us, "There are tablets I have to take and when they [care staff] are late I get worried. I take meds every time they come and should take on time and they are never on time."

Preventing and controlling infection
● Care staff were provided with equipment such as gloves and aprons which help to prevent the spread of any infections. However, records showed that some staff used poor hygiene techniques and the registered manager was not able to evidence that this had been addressed with the staff members concerned.

The assessing of risks and the management of risk in the provision of people's care was inadequate. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; learning lessons when things go wrong
● The registered manager and nominated individual had not taken steps to safeguard people from the risk of abuse. For example, not completing checks on new staff members exposed people to an increased risk of harm. The lack of managing risks and monitoring the safety of the service exposed people to the risk of neglect.
● There was a system in place which highlighted when a person's care call had not been completed. We found that when a care call was showing as not being completed this had not been investigated by the registered manager or other senior member of staff to work out what the problem was; or assure themselves that the call had been completed.
● The service had been short of staff for some time and there was no evidence that the registered manager or provider were taking enough action to reduce the risks identified from being short staffed. Only six weeks before our inspection the provider had taken on the support of a new person.

The provider had not assessed the safety and quality of the service. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- The provider was not able to demonstrate that staff received appropriate induction, training and support that they needed to be effective in their roles. The registered manager told us that they and the nominated individual provided all staff training. However, there was no evidence of this such as training certificates, training workbooks or even a record of the date when the training had taken place.
- For most staff members the registered manager and nominated individual did not have details of their work history, skills or experience. The registered manager told us that they decided if a person was suitable and had the skills for the role during an interview process. The registered manager had no records of the interview process; they told us that they didn't record information from interviews and, "remembered bits and pieces."
- The feedback about the effectiveness of staff was mixed. Some people had concerns about the skills of the care staff providing their care. One person told us, "I don't have confidence in them, they don't have enough experience."

Staff employed had not received support to be effective in their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The registered manager was not able to give us any examples of when they had assessed a person's needs, choices and preferences before providing people with care and support. The registered manager told us that they relied on the assessment of the person's needs from the local authority.
- We asked people if they received any information regarding the service they would receive before they started receiving care from staff at A Star Complex Care. Most people told us that they had limited information or opportunities to discuss their needs before the service started. One person told us, "I had no information at all, nothing. It was not a good experience."

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

- Some people fed back to us that the unreliability of the service negatively impacted on the regularity of their meals.

Staff working with other agencies to provide consistent, effective, timely care; and adapting the service to meet people's needs

- Some people told us that the unreliability of the service provided meant that it did not consistently meet their needs. For example, call times were erratic which meant that care was not always timely and care staff

were not consistently available as planned when care was needed.

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.

The service was not working within the principles of the MCA.

● People's care plans did not show that the person or somebody authorised to act on their behalf had consented to the guidelines for staff within the care plan. Some people told us they had not seen a care plan from A Star Complex Care and could not remember contributing to one.
● People told us that care staff were respectful, asked people about their choices and obtained their consent before providing care and support.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Some people said that when they had regular care staff, they felt well treated and felt safe with them. However, the unreliability and lack of communication from the service meant that people did not always feel well treated and supported.
- People's feedback included the comments, "They are often late, the eight o'clock call is often eleven o'clock which is too late. It has been impacting on the whole day, it's very, very erratic. I reckon seventy five percent of the time they are late." Another person told us, "They come in morning but not on time, sometimes at lunch they don't turn up." A third person said, "They never tell me they are running late… waiting for over hour and half it gets a bit much. There is only one number to call and no one answers. They always say we are on the way... you just sit here and wait."

Supporting people to express their views and be involved in making decisions about their care; respecting and promoting people's privacy, dignity and independence

- Some people told us that they felt frustrated because they felt that their feedback and concerns about the service were not being listened to; and the quality of the service was having a negative impact on their lives.
- One person told us, "They are decent people. It's just the organisation isn't good. I have told them, and they don't really listen but that's the way it is."

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Most people told us that they had no knowledge of and had not been involved in putting together a care plan. When we asked them, one person told us, "Nothing at all, nothing." Another person told us that they did not know if they had a care plan; they added, "I feel this is totally wrong." The care plans we looked at showed little evidence that people had been involved in putting their care plans together.
- People's care plans contained some personalised details that were important to people; however overall, they were of poor quality. One person's care plan appeared to be another person's care plan that had been overtyped; the care plan referred to the person as both male and female and contained two different people's names. This made us question if the information was relevant to the person whose care plan this was meant to be.
- Most people told us that the service did not meet their needs in some area. One person told us, "They don't come at the right time… they don't understand my needs." Another person told us, "They just come in and then gone, they only spend 15 minutes. That's not good enough." A third person said that although they thought the care staff were good, they had no idea who was going to come to care for them.

People did not receive person-centred care that met their needs and preferences. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The registered manager told us that the service did not need a system to record any complaints and their resolution; because they had not received any complaints or significant concerns.
- Some people told us that they had made complaints about the quality and unreliability of the service provided for them. One person said, "I tell them all and they just say same things, excuses all the time. I tell the managers that they are late and [there are] always excuses."

The provider has not responded to people's complaints and concerns. This is a breach of regulation 16 (Receiving and acting on complaints) 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.

● There was a theme in people's feedback that communication with A Star Complex Care was poor and that people didn't always have the information they needed.

End of life care and support

● People's care files contained no information to show that people's wishes, or preferences had been explored in this area.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.
This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- During the inspection process we found that the registered manager gave us misleading information.
- Some people told us that they had found it difficult to obtain information from senior staff within the service. One person said, "There is always an excuse when they don't turn up. Always excuses from the office. They always come up with excuses."

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

- The registered manager and nominated individual told us that because they were short of staff they spent time completing people's care calls. They had been doing this for some time been doing this for between 70 and 90 hours per week. This left them no capacity to plan improvements or to consider the safety and quality of the service being provided and how it was performing in meeting people's needs and preferences with their care and support.
- The registered manager and nominated individual had not assessed the service and had no clear plan of how they were going to improve the safety and quality of the service they were providing.

Engaging and involving people using the service, the public and staff

- There was no evidence that people had been supported to express their views with regard to the care and support they received. People also told us that they had found it difficult to get answers for their concerns.
- The feedback we received contained some concerning details; a significant percentage of this was negative. One person told us, "I'm not happy but I've put up with it."

Continuous learning and improving care; working in partnership with others

- The registered manager and nominated individual did not show that they took responsibility for the safety and quality of the service being provided. There was little evidence that until prompted by questions form the CQC that they were learning or taking responsibility with regard to things that had gone wrong or needed improving.

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

● Most people told us that care staff were nice in their manner towards them. They also told us that they knew who the registered manager of the service was; some people told us that they thought the manager was approachable when they met them.

● However, most people described areas in which the service had not meet their needs; this was mostly because the service was unreliable, erratic and they often did not know the care staff who arrived. People told us that this meant they at times had to wait an excessive period of time for personal care, medication and food. People described the disruption this caused to them. One person's relative told us, "The times are out of sync, everything is out sync. [Name] gets angry and upset… and it has [a] big impact and ongoing cycle."