Diversity Care

Diversity Care - 6A Market Street

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on the 17 June 2015 and was announced. The management were given 48 hours notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to speak to. There were 37 people using the service at the time of the inspection.

The registered manager was not available at this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of

Summary of findings

Liberty Safeguards (DoLs) and to report on what we find. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. We could not see how people who lacked capacity had been involved in decisions about their care, treatment and support.

When there had been an allegation of suspected abuse this was not always reported to the local authority for further investigation.

People had missed and were at risk of not receiving their medicines. Records related to the administration of records were not effective and had dates and dosages missing.

Assessments were undertaken to assess any risks to people who used the service and to the staff supporting them. Staff we spoke to knew the risks associated with individual people.

There were staff vacancies and the management team had covered care calls to ensure people received their agreed plan of care. However other areas of the management of the service had slipped due to staff having to diversify in their roles.

The provider could not be sure that staff were of good character and suitable to work. Recruitment checks had not been effectively undertaken.

People received health care if they became unwell or were supported to attend hospital appointments.

People were supported to maintain a healthy diet.

People told us that not all staff were kind and caring, that they were not always involved in the planning of their care and care was sometimes rushed.

People told us there was no consistency in the carers they had and that they were not always informed when their carer was going to be late.

Staff told us that they did not feel empowered and able to fulfil their role. There were no clear lines of management accountability.

There were limited quality assurance systems however the systems in place were not always effective.

We found three breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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. Incidents of alleged abuse were not always investigated. People's medicines were not managed safely. Safe recruitment procedures were not always followed. Staff were having to complete duties that they were not employed to do to ensure that people received the care they required.

Requires Improvement

Is the service effective?
The service was not consistently effective. Some staff did not feel supported and sufficiently trained to fulfil their roles. Not everyone was involved in the planning and reviewing of their care.

People's nutritional needs were met. People received health care if they became unwell and were supported to attend hospital appointments.

Requires Improvement

Is the service caring?
The service was not consistently caring. Some people felt that not all staff were kind and caring. Not everyone was involved in the planning of their care. People's confidential information was not respected.

People were supported to be as independent as they were able to be.

Requires Improvement

Is the service responsive?
The service was not consistently responsive. People did not feel informed and involved in their care. People told us there was no consistency in the carers they had. People told us they were not always informed when their carer was going to be late.

People knew who to complain to if they needed to.

Requires Improvement

Is the service well-led?
The service was not well led. Staff did not feel empowered and able to fulfil their role. There were no clear lines of management accountability. There were limited quality assurance systems. Systems in place were not always effective.

Requires Improvement

Diversity Care - 6A Market Street

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on the 17 June 2015 and was announced. We gave the provider 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to speak with.

The inspection team consisted of two inspectors.

We spoke with six people who used the service and six members of staff in differing roles. We spoke to a health and social care professional to gain their views on how the service was run.

We looked at the care records for four people who used the service to check they reflected the care they received. We also looked at staff rosters, training and staff recruitment records.

Requires Improvement

Is the service safe?

Our findings

All the staff we spoke with knew what constituted abuse and who they needed to report it. However we were informed of an incident of alleged psychological abuse which had been reported to a senior member of staff which had not been dealt with. The senior staff member had not recognised the incident as possible abuse and confirmed that the incident had not been investigated. Following the inspection the registered manager confirmed that the incident was not raised as a safeguarding referral with the local authority for further investigation. This meant incidents of alleged abuse were not being recognised and responded to.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of not receiving their medicines. We saw people's individual medication records and saw that some of the recordings of their medication and when it should be administered were written on scraps of paper, which were not dated. Some recordings did not have the dose required to be administered so staff would not know how much medicine should be given. We saw several recordings which stated that people's medication was missing. The senior member of staff was unable to explain what had been done to investigate the missing medication and whether the medication had been given. The provider could not be sure that people were receiving their prescribed medication at the time they required them.

This was breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they felt safe. One person said: "I feel safe enough, I just never know who's coming". Another person told us: "I have double-ups because they use a hoist, I always feel safe with them, they're good like that, with using the equipment." However one person told us they didn't feel safe as they had previously not received the planned care they required which had resulted in a safeguarding investigation. Assessments were undertaken to assess any risks to people who used the service and to the staff supporting them. These were recorded in their care plan. For example, risk of falls for people with mobility problems and environmental risk assessments to minimise hazards when visiting and working in people's homes. Staff were able to contact a senior staff member through the on call system in the event of an emergency.

We had previously been made aware of staff vacancies which had impacted on people receiving their agreed plan of care. The provider, manager and office staff had covered care calls to make sure that people received the care they required. We were informed by a senior member of staff that the staffing crisis was now resolved, although there were still care staff vacancies.

The provider did not always carry out appropriate checks before staff began providing care, to ensure that they were safe to care for people. Staff we spoke with told us of the checks that had been completed prior to them being offered employment at the service. However we looked at the personnel files for five members of staff and could not see references had been gained for all these staff members. These checks were required to ensure that people were supported by staff who were of good character and able to carry out the work. One new member of staff told us: "I am still waiting for my DBS so I am working with someone else until it comes". DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People who used the service said that most staff were effective in their role. One person said: “Some are very good and some are a bit amateur, but that’s because they are young”. Staff we spoke with held a mixture of views about the support they received. One staff member said: “Good staff have left because they weren’t supported, they expect such a lot of you”. Other staff were unclear of their roles and responsibilities, which meant they felt they were not effective in their role. One person said: “I don’t know what my role is, I’ve never been told, and I end up doing everything”. Staff told us they had received training in how to support people to move safely and to use equipment with people, however this had taken place in the office and was not undertaken in people’s homes, therefore the provider and people could not be sure that staff were using the equipment safely and effectively with people dependent on their individual needs.

Some people did not always have mental capacity to make decisions for themselves. We could not see that people’s capacity to make decisions had been assessed and decisions that needed to be made in their best interest identified. The MCA is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs) and to report on what we find. Some people had signed to agree to their own plan of care and others had been signed by a relative. The senior member of staff could not tell us when relatives had signed why the person themselves had not and whether they could or should have been consulted.

People were supported with their nutritional needs and staff we spoke to knew people’s individual needs. One staff member told us: “One lady likes fresh vegetables with every meal, so we peel and boil all the vegetables for her and cling film them for her to have later in the day, with a pasty or something like that”. We were informed that another person only ate a soft diet and had food supplements, one staff member told us:” [The person] loves their chocolate flavour food drink (supplement), they always drink it all”.

When people became unwell staff sought support for them. One person told us: “The staff called the GP for me the other day because my leg was red and swollen; I’ve now got some antibiotics”. Another person told us: “Oh yes, they would get the paramedics and wait with me until they came, they’ve done that for me.” We saw records that confirmed that some people were supported to attend health care appointments by care staff and that staff had to call for paramedics on occasions when a person had been taken unwell.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their representatives had a mixture of views about whether the service they received was caring. One person said: "Some staff are nicer than others". Another person said: "Some are very caring, others are not, I've not raised it with anyone but sometimes there's just an atmosphere that's not very nice. Sometimes they just aren't friendly." However other people told us: "Most of the girls are lovely. They come in two's and they talk to me, not each other, they are so kind and sweet. I love it when we have a laugh and a joke because I'm on my own all day so I love that". Another person said: "The one's that come this week are great, I wish I could have them all the time, I love them."

People told us that they were mostly treated with respect. One person said: "Oh yes they are respectful". However someone else told us: "Once two staff were rushing me, saying hurry up we will be late for our next call". We were also made aware of an incident which had been reported by a member of staff that alleged that two staff members were witnessed to have spoken disrespectfully to a person.

People again gave us a mixture of views on whether they felt involved in their care planning. One person said: "I haven't been asked about my care. There's a file on the kitchen table, if I want to read it I ask the girls to bring it to me and they do, I can't get to it myself. No-one has asked me what I want or what I like though; I don't really know what's in that file they write in it when they come to me to say what they've done." Another person said: "No, I haven't. Someone from the office only comes occasionally to check on the girls." However one person said they had discussed their care, they said: "Yes, I have had a meeting with the manager and my friends". The senior member of staff told us and showed us a recent review of person's care package that had recently taken place.

People's confidential information was not being respected. We were informed that some care staff had left people's individual care records in their cars when their cars were being driven by someone else not related to the service. This was confirmed by the quality manager. This meant that people's confidential information was at risk of being lost or shared with people who were not required to see it.

People were encouraged to be as independent as they were able to be. Some people were supported to make and meet new friends because staff supported them to social events. One person's social worker had reported that the person's wellbeing was being maintained from these outings.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to receiving a service. Care plans and risk assessments were put in place using the information in the assessment and gained from the person themselves or their representatives. People we spoke with told us that they did not feel involved in the reviewing of their care following the initial assessment. One person told us: "When someone from the office comes, they don't ask me anything, they are just checking what the girls are doing not to see me."

All the people we spoke with told us that there was no consistency in the carers they had. One person said: "I wish I could have the ones I like all the time but there's always different one's coming." Another person said: "You never know who's coming, especially in the evenings". Someone else said: "They have to keep changing the runs so there's always someone different coming." We were told by a health professional that supported people who used the service that one person who required consistency in the support they received from staff due to their learning disability had a recent change in staff. They had not been informed so that they would be able to support the person through their feelings of loss. This meant that this person was not having their needs recognised and responded to.

Staff we spoke with told us they always checked the person's daily notes before commencing any care. They told us this was to ensure that people's care needs had not changed since they last visited the person. We saw that the management texted staff members on their mobile phones to update them of any changes. Some of the information in the care plans we looked at had not been reviewed and did not reflect people's current care needs. We asked if the information was the same as in people's homes and we were told it was. This meant that care records did not always reflect these people's current care needs.

Staff told us they would ring people if they thought they were going to be late. However we telephoned one person who told us that there carers were late that day and they had not received a phone call to say where they were. This person was not able to have their breakfast or use the toilet until their care staff arrived. Another person told us: "Sometimes they let me know if they are going to be late. Once I was left all night in my chair". This was confirmed and investigated as a safeguarding incident.

People were encouraged to be independent and access the community. We saw that the manager and staff worked with other agencies to ensure that the care was being delivered was responsive to the person's needs and preferences. We saw and people told us they were supported into the community, shopping and other activities.

People told us they knew there was a complaints procedure. However several people told us that they had complained but there had been no improvements in the care they received. This meant that the complaints procedure was ineffective.

Requires Improvement

Is the service well-led?

Our findings

People who used the service had a mixture of views about whether they thought the service was well led. One person said: “I don’t know about that, I’d query it. The right hand doesn’t seem to know what the left hand’s doing.” Another person said: “We have had meetings in the past when things have gone wrong and then things are ok for about three weeks and then it goes wrong again, they haven’t got it organised”. Other people told us: “I’m happy, I wouldn’t change anything”, and: “On the whole, if I get the good staff that I like.”

Staff we spoke with were unclear of theirs and other's roles and responsibilities. One staff member said: “I don’t know who to speak to in the office, there are so many of them”. Not all staff felt supported to fulfil their role effectively. Some staff told us that they had not been trained in their role, and that they were unclear of their responsibilities. Other staff told us they had tried to suggest new ideas to the manager and provider but felt they had not been receptive to the ideas.

People’s records were not well maintained and stored securely. We saw that people’s daily progress notes were brought back to the office periodically. There was no set time scales and some people had up to two years’ worth of records kept at their home. Records that came back into the office were not checked for quality. We saw that dates and times of care interventions were missing. Staff had written the administration of people’s medication on scraps of paper with no dates or doses. Nothing had been done to quality assure and address the issues found in people’s care records.

Staff recruitment systems were not followed to ensure that the quality of staff being employed was of an acceptable standard. References from previous employers were not available for several members of staff. We spoke to the registered manager following the inspection who told us that it had been someone else’s responsibility to gain references at the time of recruiting them. This meant that the provider could not be sure that people were fit to work.

The provider used a system which monitored the times staff arrived and spent at each person’s home. However we spoke with one person who used the service who told us: “They [the staff] are over 45 minutes late today and have not rang me, I can’t have my breakfast or go to the toilet until they come”. Other people described incidents of their calls being late. This meant that the system was not effective in ensuring that the quality of time keeping was monitored, reviewed and improved.

There was a quality assurance manager who was awaiting further instruction in their role. They had currently begun with carrying out spot checks on staff. The checks were to ensure that staff were fulfilling their role effectively. No other quality monitoring systems were available to see on the day of the inspection.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— g. the proper and safe management of medicines;

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 1. Service users must be protected from abuse and improper treatment in accordance with this regulation. 3.Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

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.