Zion Care Services Limited

Zion Care Services Limited

Inspection report

9 Waterloo Road
Wolverhampton
West Midlands
WV1 4DJ

Tel: 07368934880
Website: www.zionhealthcare.co.uk

Date of inspection visit:
04 October 2022
13 October 2022

Date of publication:
20 January 2023

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**

Summary of findings

Overall summary

About the service
Zion Care Services Limited is a domiciliary care agency providing personal care to people living in their own houses and flats. At the time of our inspection, the service was supporting 71 people with personal care.

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 not always supported safely. People's medicine administration records (MAR) were not always accurate and medicines weren't always administered safely. People were supported by staff who told us they had not received safeguarding training and did not always understand how to keep people safe. Risk assessments were in place but were not consistently followed by staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were not always supported by staff who were fully trained to meet their needs. Relatives told us staff did not understand people's dementia needs. People's assessments were not always holistic and did not consider people's diverse needs. Staff did not always ensure people received food and drink in line with their dietary needs and preferences. Staff did not always contact health professionals when needed.

Staff did not always spend meaningful time with people due to them being rushed. Staff sometimes conversed with each other in a language that people did not understand which relatives found disrespectful. People's records did not always use dignified language.

People's care plans did not always provide consistent and clear guidance for staff to meet people's needs. Staff did not always communicate with people in a way that maximised their understanding. A complaints policy was in place, but complaints were not always dealt with in line with the policy.

Systems in place to check the quality of the service were not always effective. For example, they failed to identify medicine recording errors or the lack of mental capacity assessments in place. The registered manager and staff were not always aware of their roles and responsibilities. People were asked for their views about the service, but sufficient action wasn't always taken to improve the service.

Staff wore Personal Protective Equipment (PPE) in line with current guidance. Staff had worked alongside health professionals to ensure they were adequately trained to meet a person's complex clinical needs. People and relatives told us staff were lovely and caring. Relatives told us the registered manager was

supportive and approachable. The provider had engaged positively with commissioners to improve the service.

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 14 April 2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to a range of concerns received regarding medicines, risk management, mental capacity and safeguarding. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive 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.

Following the inspection, the provider took immediate action to reduce risk to people they supported. The provider voluntarily agreed to not take on any further care packages until their systems were adequately improved and records had been fully transferred from a paper to electronic system. The provider also confirmed they had allocated a senior for every area they provide care for so there was more oversight.

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 person centred care, consent, safe care and treatment, staffing and governance at the service at this inspection.

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 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Zion Care Services Limited

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 team consisted of 4 inspectors and an 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure the registered manager would be in the office to support the inspection and to ask them to request consent from people and relatives for us to contact them.

Inspection activity started on 4 October 2022 and ended on 13 October 2022. We visited the location's office/service on 4 and 13 October 2022.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and commissioners of care. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the registered manager, a care co-ordinator and 9 care staff. We also spoke with 1 person who received support from the service and 8 relatives.

We looked at 10 people's care records and reviewed 6 people's MAR. We also viewed 3 staff files, call log records and documentation related to the governance of the service.

The provider sent us further documentation we had requested during and following the site visit including training records and action plans.

Requires Improvement

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 of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Staff did not always check medicines prior to administering them which placed people at risk of harm. For example, one person was administered the incorrect medicine which resulted in paramedics being called. The provider raised a safeguarding and the staff member was required to undertake additional medicines training and competency checks.
- Medicines were not always administered safely. For example, one person had received a double dose of medicine which placed them at risk of harm.
- The service's responsibilities regarding medicines administration was not always clear. For example, 1 person's care plan stated they needed support with medicines administration but their MAR showed medicines had been self-administered on occasions.
- MAR did not always accurately reflect people's prescriptions which meant people were at risk of not receiving their medicines as prescribed. For example, medicine dosages were sometimes missing from MAR charts and medicines were sometimes duplicated.

Systems had not been established to ensure medicines were being administered safely to people. This placed people at risk of harm. This was a breach of regulation 12(1) 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

- Systems in place did not always keep people safe.
- People were supported by staff who told us they had not received safeguarding training and did not always understand how to keep them safe. One staff member told us, "I've not had safeguarding training and I cannot remember the types of abuse." The registered managed showed us the training matrix which evidenced staff had received safeguarding training. The registered manager immediately implemented an action plan which included all staff completing updated safeguarding training and additional guidance being made available on the electronic application so staff had access to it at all times.
- An accidents and incidents policy was in place and the registered manager analysed accidents and incidents on a monthly basis. However, not all accidents and incidents were recorded which meant that this analysis was not always accurate.
- Staff were not always aware when to escalate safety concerns. For example, where medicines errors were made, staff failed to identify this and escalate their concerns.
- When things went wrong, they were not always investigated sufficiently to reduce the risk to people. For example, where call times were cut short, they were not always investigated and action was not always taken to reduce the risk of reoccurrence.

Assessing risk, safety monitoring and management

● Risk assessments were in place to guide staff how to manage people's mobility needs. However, staff did not always follow these. One relative told us a staff member had used an unsafe technique when supporting them with transferring. We reviewed the person's records and saw the registered manager had addressed this with the staff member.

● Where people had complex clinical needs, risk assessments were in place to guide staff how to manage risk to people. One relative told us staff followed the risk assessment and their family member's needs were met safely by staff.

Staffing and recruitment

● Call logs showed that staff were often late and relatives told us staff seemed rushed. One relative told us, "I know we have set times but I can't remember the last time the carers came at the proper time."

● People and relatives told us they were rarely told if staff supporting them changed so they didn't know which care staff were going to arrive.

● Staff recruited did not always have the appropriate skills or knowledge to meet people's needs and gaps in their knowledge were not always identified. For example, staff did not always have sufficient English language skills or knowledge about specific health conditions they needed to meet people's needs safely.

● People were supported by staff who had reference checks and Disclosure and Barring checks in place prior to starting employment. Disclosure and Barring (DBS) checks were undertaken prior to staff starting employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● Suitable systems were in place to manage infection control.

● An infection prevention and control policy and risk assessment were in place to guide staff on how to reduce the risk of spread of infection.

● People were supported by staff who followed the infection prevention and control policy and wore personal protective equipment (PPE) in line with guidance.

Requires Improvement

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 requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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.

- Mental capacity assessments were not completed when required. The registered manager confirmed the provider did not complete their own mental capacity assessments, but referrals were made to health professionals if one was needed. This meant people's mental capacity assessments were not completed on a decision and time specific basis as required by the MCA. Therefore, people were not always able to consent to care and treatment in line with the law.
- People's documentation was inconsistent regarding whether they had capacity to make decisions independently. For example, some people's care plans stated they had capacity, but their documented outcomes indicated relatives would make final decisions on their behalf. This meant we could not be assured that people were being supported to make their own decisions.
- Staff did not always understand what to do to ensure people's needs were met in their best interests. For example, where one person lacked capacity, their relative had raised concerns with the provider and with CQC regarding staff failing to act in their best interests, when they declined care.

Systems had not been established to ensure care and treatment was provided with the consent of people in line with the Mental Capacity Act 2005. This was a breach of regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- People were supported by staff who were not always sufficiently trained to meet their needs. For example,

relatives told us staff did not always seem knowledgeable about the needs of people living with dementia.
● Staff were required to complete Care Certificate training but not all staff were up to date with their training. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Staff supervisions were undertaken when there had been a concern raised regarding a staff member or there had been an identified error. However, they were not always undertaken regularly to enable the registered manager to identify any potential training needs.

The provider failed to ensure staff were sufficiently trained, knowledgeable and competent to meet people's care needs. This placed people at risk of harm. This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were supported to undergo external training when needed to meet a person's specific clinical needs. One relative told us all staff members were well trained to meet their family member's complex needs effectively.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always assessed holistically. Assessments were inconsistent and some people's assessments lacked detail and information regarding their needs and choices.
● Assessments did not always consider people's diverse needs in line with the Equality Act 2010. For example, assessments did not always detail people's needs related to their sexuality or religion.
● People's assessments did not always consider the outcomes and goals they would like to achieve.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported to eat and drink in line with their preferences. One relative told us that staff did not always prepare food in the way their relative liked.
● People were not always supported by staff who knew how to meet their dietary needs. For example, records showed a district nurse had raised concerns regarding care staff not supporting a person in line with their dietary care plan.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff did not always contact health professionals when people needed support. For example, 1 person was found on the floor following a fall and the staff member failed to seek medical attention. The registered manager discussed this with the staff member who stated this was the person's choice. The process regarding seeking medical attention was reiterated to staff by the registered manager.
● Staff worked alongside specialist nurses to provide effective care to people. Where one person had complex clinical needs, staff had been trained by specialist nurses to ensure they were sufficiently skilled to provide their personalised care.

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
- Staff were not always able to spend meaningful time with people and people and relatives told us they often seemed rushed when providing care.
- People and relatives told us staff treated them well. One relative told us, "The carers are so lovely to [my relative]."

Supporting people to express their views and be involved in making decisions about their care
- People were not always supported to express their views due to care staff being rushed and not always fully understanding people due to English not being their first language.
- Staff did not always recognise people's preferences or when they wanted support. Staff were often late for calls which meant people did not always receive care at a time that had been agreed.

Respecting and promoting people's privacy, dignity and independence
- Relatives told us staff sometimes conversed in their own language whilst providing care, which they did not find respectful. One relative told us, "It can be difficult to understand the carers sometimes. I had to ask them not to speak in their own language in front of my relative as I feel it's very rude."
- However, people and relatives also told us they were treated with respect. One relative told us, "The staff are all very respectful to me and my relative."
- People's records did not always use language that was dignified. For example, where one person required support to eat, their care plan guided staff to, 'Feed them'.
- People's care was delivered in a way that respected their privacy. One relative told us, "I hear the carers talking to my relative all of the time while they are doing things and they always make sure the bedroom door is closed to maintain their dignity."

Requires Improvement

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 requires improvement. This meant people's needs were not always met.

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

- People's care plans were inconsistent and were not always reviewed regularly. Some care plans provided clear guidance to staff how to meet people's needs but others lacked detail and were not always personalised.
- People were not always supported in a person-centred way that reflected their wishes and preferences. Relatives told us this was because staff did not always have time to do this.
- Care plan documentation was not always accurate. This meant staff were not always provided with consistent guidance to follow to ensure they were meeting people's needs. The registered manager told us this would be reviewed immediately and was due to the change over from paper to electronic records.
- People's care plans did not always use language appropriate to reflect their life stories and needs. For example, one care plan described a person's background as a 'normal' background.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People were supported by staff who did not always meet their communication needs.
- Relatives told us they had difficulty understanding some staff due to a language barrier. One relative told us, "It can sometimes be hard to understand what the carers are saying, especially as they all have a mask on, we muddle through."
- Where people had sensory impairments or dementia needs, staff did not always understand how to communicate with them to support them to maximise their understanding.

Systems in place did not always ensure that the care and treatment of people was appropriate and met their needs and preferences. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Recording of complaints and concerns was not consistent. Some issues had not been formally recorded and investigated in line with the provider's complaints policy to ensure action was taken to improve practice.

● Analysis of complaints was not accurate because it did not include the unrecorded issues.

End of life care and support

● People's end of life wishes and preferences had not been considered in their care plans.

● Where people had respect forms in place, this was documented in their care plans. A respect form is a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

Requires Improvement

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 requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems in place to check the quality of the service were not consistently effective to ensure concerns were identified and action taken to address them.
- Medicines audits failed to identify where paper MAR documentation was not effective in ensuring medicines were administered safely. For example, audits did not identify where MAR did not record medicine dosages for staff to refer to, where medicines had not been administered, or where medicines had been duplicated on the MAR.
- Checks were not sufficient to ensure information had been transferred over from paper records to electronic records accurately. This meant there were inconsistencies in people's care plans and information contained in MAR did not always guide staff how to administer medicines safely.
- Systems in place were not effective to ensure calls were on time and people received their full call time. Call logs showed a high number of late calls and relatives told us calls were regularly late. The registered manager told us this was due to care staff attending calls in the same vehicle so if one staff member was late, all calls following that were late or cut short.
- Staff supervision and training systems were insufficient to ensure staff had appropriate skills to meet people's specific needs. For example, where concerns were raised about staff knowledge around dementia and the Mental Capacity Act and the English language skills of some staff members, insufficient action was taken to upskill staff to enable them to improve the quality of the service.
- When things went wrong this was not always immediately shared with people and relatives. For example, relatives told us they weren't always informed when care staff were late. One relative told us, "I ring up to find out where the carers are and when they will be coming, I never get a phone call to tell me."

Systems had not been established to ensure the quality and safety of the service was assessed, monitored and improved effectively. This placed people at risk of harm This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Staff were not always aware of their roles and responsibilities. For example, it was not always clear who was responsible for medicines administration which meant staff did not always take responsibility for ensuring people's medicines were administered safely.

● The registered manager did not always understand the risks and issues facing the service. For example, when we discussed how inaccurate recordings on MAR charts placed people at risk of harm, the registered manager did not initially understand why. However, they welcomed feedback and showed a willingness to want to improve their knowledge and make improvements to the service.
● Relatives told us the registered manager was supportive and communicated with them effectively. One relative told us, "Communication is good, the manager rings regularly to see if all is okay."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
● Feedback was requested from people and their relatives and this was monitored on a monthly basis. Sufficient action was not always taken to improve the service based on feedback given. For example, one person fed back there was a language barrier with some staff but at the inspection we found this was still a concern.
● Improvements were not always identified to enable the provider to improve the care people received.
● Where concerns were identified, action taken was not always adequate to improve care to people. For example, where late calls had been identified as a concern, staff had been spoken with and travel times had been amended. However, call records showed there continued to be a high number of late calls.
● Staff meetings were held with staff on a monthly basis where staff had the opportunity to input into the service.

Working in partnership with others
● The provider had engaged with the local authority in a quality assurance process. There had been some positive engagement with health commissioners.
● The provider expressed motivation to work in partnership with others to improve the quality of care provided to people.

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 9 HSCA RA Regulations 2014 Person-centred care Systems in place did not always ensure that the care and treatment of people was appropriate and met their needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems had not been established to ensure care and treatment was provided with the consent of people in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were sufficiently trained, knowledgeable and competent to meet people's care needs.

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 Systems had not been established to ensure medicines were being administered safely and risk was being mitigated to people.

The enforcement action we took:

We served a warning notice and asked the provider to evidence how they had made improvements to evidence compliance with the regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to ensure the quality and safety of the service was assessed, monitored and improved effectively.

The enforcement action we took:

We served a warning notice and asked the provider to evidence how they had made improvements to evidence compliance with the regulation.