CRUCIALCARE LIMITED

CrucialCare Limited

Inspection report

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Date of inspection visit:
14 October 2019

Date of publication:
28 September 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
CrucialCare Limited is a domiciliary care service providing personal care 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 the inspection the service was supporting eight people with a regulated activity. All of the people receiving support were receiving end of life care.

People's experience of using this service and what we found
People received a service that was not safe, effective, caring, responsive or well-led. The provider, who was also the registered manager was unable to evidence they had established systems to ensure the safe and effective running of the service. Records, which the provider is required to maintain, were of poor quality, inconsistent or unavailable. We were prevented from contacting people or staff for their feedback, as the provider failed to supply contact details as requested.

People were not protected from the risk of harm or abuse as the provider had not ensured staff were trained to identify signs of abuse. Furthermore, the provider was not aware of their responsibilities to protect people from harm and had failed to escalate allegations of abuse with the safeguarding authority. This placed people at risk of future harm.

Due to a lack of available information, the provider was unable to demonstrate people received safe support with their medicines. This placed people at risk of harm. The provider failed to operate safe recruitment practices and as a result people were placed at risk of receiving care from staff who may not be suitable to work with vulnerable people.

Care plans, where available, were inconsistent and did not reflect how changes in people's needs had been assessed, recorded or shared with staff. Due to the lack of records, we were unable to confirm if people's risks had been assessed. Care plans lacked clear guidance and information for staff which placed people at risk of receiving unsafe care.

The provider was unable to demonstrate staff had received training relevant to their role. They had not assessed the competency of staff in their employment, so could not assure themselves staff were fit to provide care and support.

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.

All of the people receiving support were at the end of their lives. However, care plans did not contain details of people's end of life wishes. The provider had also failed to ensure staff were trained to deliver end of life

care to people. A lack of available information and the absence of contemporaneous records and care plans meant we were unable to assure ourselves people received care that was dignified and person centred.

The service was not well-led. The provider had failed to establish systems to ensure effective oversight of the service and were unable to evidence they had sought feedback from people and staff. The provider had also failed to notify relevant agencies about safeguarding concerns and had failed to submit notifications to CQC as required by law.

Information requested during and following the inspection was not provided.

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 12 November 2018 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about unsafe recruitment practices. 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.

Enforcement
We have identified breaches in relation to safe recruitment of staff, safe care and treatment, safeguarding people from abuse and the governance of the service at this inspection.

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 until we 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?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not 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.

CrucialCare 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

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 24 hours' notice of the inspection. This was because we needed to be sure that the provider would be in the office to support the inspection.

Inspection activity started and ended on 14 October 2019. We also visited the office location on 14 October 2019.

What we did before the inspection
We reviewed information we had received about the service since registration. This included checking for any statutory notifications that the provider had sent to us. A statutory notification is information about important events which the provider is required to send us by law. We had not received any. We contacted the local authority commissioning team for feedback; they told us they did not currently fund anyone who used the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the

service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
During the inspection we visited the office location however there was only limited information and records available to review. We spoke with the provider who said they would send us the required information immediately following the inspection visit also spoke with the clinical lead. We requested contact details for people who received a service and for staff members. The provider failed to send them, so we were unable to speak with people and staff about their experiences.

After the inspection
We requested evidence of safe recruitment practices and a list of all staff employed by the provider. We also asked for the induction and training records for each staff member. The provider failed to send this information.
Following the inspection we contacted the Clinical Commissioning Groups (CCG) who were responsible for funding people's care. They took immediate action to ensure people were safe. The CCG advised the provider had contacted them to request alternative provision be arranged for people, following concerns highlighted at the inspection.

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.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of abuse because the provider could not demonstrate staff had been trained to identify signs of possible abuse. We were unable to speak with staff to clarify their understanding of safeguarding as the provider was unable to confirm who they employed. Although they had limited records for some staff, they were not able to supply us with the full names of all staff who had provided care for people.
- Following an allegation of abuse, the provider failed to follow locally agreed multi agency guidelines for reporting abuse. The provider told us they had not considered referring the allegations to the local authority responsible for investigating safeguarding concerns. The provider's own investigation failed to identify what was needed to protect the person from further alleged abuse. Furthermore, the provider was unable to evidence other actions taken as they told us they had disposed of the records.

This 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.

Staffing and recruitment

- The provider confirmed that pre-employment checks had not always been carried out for staff who were delivering care to vulnerable people. They told us these had been done to 'varying degrees of compliance'. As a result the provider was unable to demonstrate they had carried out safe recruitment checks for people in their employment. During the inspection the provider told us they employed 14 staff members. They provided us with a list of staff names. However, when we reviewed the staff rota and care records these contained staff names that were not listed as being in the provider's employment.
- The provider showed us recruitment checks for six members of staff. We found these records were limited and incomplete. Information about some staff member's identity, right to work, previous employment history, qualifications and skills were missing.
- Care records contained signatures of staff members who had delivered care and support to people at the end their lives. In two cases the provider was unable to confirm who had provided care to a person and was unable to tell us the staff member's full names.

This placed people at risk of receiving care from people who were not suitable or safe. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Due to the lack of records we were unable to confirm if people's risks had been assessed. We found care

plans lacked clear guidance and information for staff.
● Where records were available we found information was inconsistent. For example, where people were being supported with their mobility, care records completed by staff were conflicting in whether or not a person could bear their own weight. The provider told us staff were using 'different words for the same thing'. However, this could place the person at risk of receiving care that did not meet their needs.
● The lack of clear guidance and absence of risk management plans could place people at risk of harm.

Using medicines safely
● Due to a lack of information relating to people's medicines, the provider was unable to demonstrate people received their medicines safely. This placed people at risk of harm.
● The provider was unable to confirm staff had received training in how to safely support people with medicines. The clinical lead told us they had assessed the competency of some staff, however there were no records of these assessments.
● There was conflicting information in care records about how people received their medicines. For example, one person's care plan stated family members administered the person's medicines; however, daily care records contained staff signatures confirming they had administered the medicines.

Preventing and controlling infection
● There was no evidence to demonstrate staff had received training in infection prevention and control.

People were place at risk of harm because the provider did not have effective systems in place for the management of risk or the safe administration of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The provider did not have any systems in place to ensure actions were taken to improve safety for people. There was no evidence of how staff would learn from reviews of incidents or concerns.

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.

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

- The provider could not demonstrate they had completed an assessment for all of the people they supported, of their specific and individual needs. The provider told us they were providing care for eight people at the time of the inspection. However, they could only provide partial care records for five of those people.
- The care records we were able to review, contained conflicting or unclear information.
- Due to a lack of records, the provider was unable to offer assurances that people received timely care that met their individual needs.

Staff support: induction, training, skills and experience

- The provider could not provide evidence of training staff had completed since their employment with Crucialcare. We reviewed copies of training certificates which showed some staff had received training in their previous roles. However, the provider had not taken steps to assure themselves of the competency of staff.
- We asked the provider to send us details of staff induction and training, however they failed to do so.
- We were unable to speak with staff about the training and support they received because the provider failed to send us staff contact details.

The provider could not be assured staff had the appropriate skills and knowledge to effectively support people. This placed people at risk of receiving unsafe care. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Records were not available to show how people's dietary needs were met.
- We were unable to speak with people about the support they received with food and drink because the provider failed to provide contact information for people they supported.

Staff working with other agencies to provide consistent, effective, timely care

- Some people's care records reflected the involvement of other agencies, for example, the district nursing team, in the person's support. However, due to the lack of records and contact information the provider was unable to offer assurances that staff worked with other agencies to provide effective, timely care.

Supporting people to live healthier lives, access healthcare services and support

- People received support with personal care from staff. Support for healthcare needs was provided by

other agencies. We were unable to confirm how the provider supported people's health care needs as records were not available.

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.
- Due to the limited information contained in care plans we were unable to establish whether the provider was working within the principles of the MCA.
- We saw one care plan that had been signed by the person receiving support to confirm their consent to receiving care.

Inadequate

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 inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- Due to a lack of information as well as being unable to speak with people or staff members, we were unable to assess whether people were well treated by staff or received care that respected their diverse needs.
- The provider told us they had undertaken spot checks to review how staff were delivering care, to assure themselves of the quality of care people received, and if they were happy with the care provided or if staff treated people well. However, they told us this had not been recorded so we were unable to view feedback received from people about the quality of their care.
- Staff recruitment and personal information was missing or inaccurate, so the provider could not assure themselves that staff were suitable to work with vulnerable people. This placed people at risk of potential harm.

Respecting and promoting people's privacy, dignity and independence

- We were unable to speak with people about their experiences as the provider failed to share contact details for people who received support.
- Due to a lack of available information and limited care records we were unable to establish whether people receive care that promoted their independence or protected their privacy and dignity.

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

- Due to missing or partial records we were unable to establish how people were supported to be involved in decisions about their care.
- The provider failed to demonstrate they had systems in place to support people in making decisions about their care.

This was a breach of regulation 17, (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider could not evidence how they assessed people's changing needs to ensure people received up to date care.
- We were unable to speak with people about how their needs and preferences were met. We were unable to speak to staff to hear their views on how they provided support which met people's current needs.

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.

- The provider was unable to demonstrate how they met people's individual communication needs. They did not have information available in different formats to support individual communication. As a result, people may not fully understand information shared with them by the provider.
- Following the inspection the provider confirmed that the service user guide was available in large print, easy read and audio version, should this be required.

Improving care quality in response to complaints or concerns

- The provider told us they had a complaints procedure, which was contained in their statement of purpose and provided to us at the point of their initial registration. However, but we could not be assured how this was shared with people as the provider was unclear about whether or not people received a copy.
- We reviewed records of complaints, one of which reflected poor care and indicated a person may be at risk from staff. The provider failed to demonstrate this had been managed safely in the best interests of the person. They were unable to evidence actions taken in response to the complaint as they told us they had disposed of the records.

End of life care and support

- All of the eight people receiving support at the time of the inspection were receiving end of life care. However, the care plans we looked at did not reflect people's end of life wishes.
- The provider was unable to demonstrate staff had received training in end of life care.

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.

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

- The service was not well managed. Information to ensure the effective and safe operation of the service was not available. Essential information required to deliver safe, effective and compassionate care was missing or inaccurate. Recruitment practices were not safe.
- The provider, who was also the registered manager told us they struggled to maintain effective oversight of the service as they spent much of their time delivering care and support to people.
- The provider failed to provide details of people who received support and staff members and therefore did not co-operate with the inspection process.

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

- Due to a lack of available information and poor record keeping, the provider was not able to assure themselves that they promoted a positive, person centred culture.
- We were unable to speak with people to gather their views, so were unable to ascertain whether the service they received, resulted in good outcomes.

The provider failed to establish systems and processes to ensure effective governance of the service. This placed people at risk of receiving poor quality, unsafe 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

- The provider had failed to act in accordance with the duty of candour regulation. Records relating to actions following concerns had been disposed of which meant the provider had no written record of their actions. The duty of candour is a legal duty to be open and transparent when things go wrong.

This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The provider was unable to demonstrate how people using the service, the public and staff had been

engaged and involved in feedback, or service improvement.
● We saw how one concern had been responded to by the provider. However, there were no records to indicate how any learning had been implemented to reduce the likelihood of reoccurrence. The provider could not evidence they had made changes or improvements as a result of receiving the information.

The provider failed to notify us of incidents and events as required by law. This was a breach of Regulation 18 (Notification of other incidents) (Registration) Regulations 2009.

Working in partnership with others
● The provider worked with agencies responsible for funding people's care. However, we were unable to speak with them about the individual care people received, as the provider did not share the information with us when requested.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify us of incidents and events as required by law.

The enforcement action we took:

Notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were place at risk of harm because the provider did not have effective systems in place for the management of risk or the safe administration of medicines. We could not be assured staff had received training in risk management, infection control or safe handling of medicines.

The enforcement action we took:

Notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to take appropriate action when informed of allegations of abuse.

The enforcement action we took:

Notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish systems and processes to ensure effective governance of the service. This placed people at risk of receiving

poor quality, unsafe care.

The enforcement action we took:

Notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure person's employed were safe to work with vulnerable people.

The enforcement action we took:

Notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not acted in an open and transparent way with relevant persons in relation to care provided.

The enforcement action we took:

Notice of proposal to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure persons employed by the service had received appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

Notice of Proposal to Cancel the provider's registration.