Obasan Services Limited

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Inspection report

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Date of inspection visit:
13 August 2018
15 August 2018
16 August 2018
17 August 2018

Date of publication:
08 October 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Obasan Services Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing. Not everyone using Obasan Services Limited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. When we visited the service there were 14 older adults receiving 'personal care'.

This was the first inspection of this provider since they became registered with the Care Quality Commission in January 2018.

The manager and staff had a strong ethos of person centred care and worked hard to ensure that people had regular staff visiting them. This was appreciated by people and relatives who were mostly happy with the service they received and spoke highly of the staff and registered manager; identifying their caring natures and keenness to be responsive.

We found a number of areas of concern due to a lack of robust systems and oversight. There were breaches of regulation in relation to safe care and treatment, recruitment, the application of the Mental Capacity Act 2005 and the governance of the service.

People were at risk of harm because the oversight and administration of medicines was not robust, and risk assessments had not led to care plans containing current guidance for staff.

Staff understood how to identify and report abuse and were confident that concerns would be taken seriously by the registered manager.

Staff had not completed all the training the provider had determined to be essential to their roles, and whilst some of these staff had undertaken training with previous employers the registered manager did not have a system in place to record that their competence had been assessed.

Communication was considered and staff supported people to understand the choices available to them. People told us that staff enabled them to have choice and control of their lives. The systems in the service did not wholly support this as documentation to support the application of the Mental Capacity Act was not available.

Care planning and assessment did not always contain personalised information to ensure preferences were clear and to ensure characteristics protected by the Equalities act were respected. We have made a recommendation about this.

People and relatives mostly told us they could raise any concerns and these were addressed appropriately. We also received feedback from a relative who had not been happy with care and responsiveness.

Whilst the registered manager had contact with people, relatives and staff due to the size of the service. Quality monitoring processes had not been implemented.

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. Risks associated with people's care were not managed effectively. People did not always receive their medicines as prescribed.

Staff understood how to report concerns about abuse.

The registered manager was addressing the need to recruit more staff.

Is the service effective?

Requires Improvement

The service was not effective.

People were not cared for within the framework of the MCA. Health needs were not sufficiently reflected in care plans.

New staff were completing the Care Certificate, but staff had not had their competency reviewed and recorded to ensure they were able to fully carry out their role.

Is the service caring?

Good

The service was caring. People felt cared for by staff they saw regularly.

People were supported to retain independence to meet their wish to stay in their own homes.

Is the service responsive?

Requires Improvement

People felt the care they received met their needs, however some people felt that their preferences were not listened to, and acted upon.

People they knew how to complain if necessary.

Is the service well-led?

Requires Improvement

The service was not well led. Quality assurance systems were not developed or implemented to ensure the safety of the service.

People and relatives liked the ethos of the service and staff felt

supported by the registered manager.

Obasan Services Limited

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 announced inspection started on 13 August 2018, we began to make calls to people, relatives and professionals on this date and visited the office on 15 August 2018. We made further calls on 16 August 2018. The inspection team was made up of one inspector.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us and information received from other parties. The provider had not submitted a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We had not requested this information but we were able to gather this using registration documentation and information gathered during the inspection.

During our inspection we spoke with two people and four relatives of different people. We spoke with three members of staff and the registered manager. We also spoke with a social care professional who had worked with the service. We looked at seven people's care records, and reviewed records relating to the running of the service. This included four staff records. We requested information to be sent to us by 17 August 2018. This information related to medicines management, staff meetings, and staff business insurance. We received most of this information on this date and the remainder shortly afterwards.

Inadequate

Is the service safe?

Our findings

People were supported by staff who understood risks people faced and were motivated to support them to live full lives. Most relatives told us they were confident in the competence of staff and believed that their loved one felt safe. The registered manager told us they worked alongside staff with people and others who knew them well to assess risks and develop plans together. Care plans did not always detail how identified risks would be met. For example, in relation to nutrition and self-neglect. This had led to a delay in involving social care professionals.

Most risk assessments were not available for us to view at the service. The registered manager told us that this would be addressed immediately. It is important that the registered manager has an overview of people's needs and can ensure the outcome of current risk assessments are reflected in people's care plans. This was not the case. For example, one person's risk assessment relating to their mobility had been reviewed but this had not led to a change detailing the equipment they used on the person's care plan. This failure to undertake updated risk assessments meant people were put at risk. During the inspection we were not able to review more risk assessments because the registered manager was only able to access one of the people's records we requested.

People did not always receive their medicines as prescribed and staff competency was not assessed in a robust manner. Medicine management systems were not always effective. This meant that one person did not receive their pain relief as prescribed for more than one month because the directions had been incorrectly transcribed onto their Medicines Administration Record (MAR). There were risks associated with both the application and disposal of this medicine that were not recorded on the person's care plan or MAR. We raised a safeguarding concern about this with the local authority. There were also two prescribed medicines that they regularly refused. The reason for this refusal was not recorded and had not led staff to initiate or prompt a GP review of medicines prior to our inspection. Another person took medicines that were time dependent and needed to be taken before eating to ensure its best impact. There was no information about this on their MAR and records indicated that they took this medicine either before or after breakfast.

Staff giving medicines had been observed by the registered manager, however, there was no record of this or the detail of the observation. The registered manager told us they would implement a competency assessment immediately.

Risks faced by staff were not clearly recorded. When a person's lifestyle raised risks to staff entering their home these had not been assessed or guidance issued to staff that prioritised their safety. We discussed this with the registered manager who told us that this would be addressed in a forthcoming meeting with statutory agencies. This meeting was not the result of issues highlighted by the service. This indicated that the service did not have robust systems for identifying and appropriately reporting and addressing these risks to staff.

These shortfalls were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks related to people's care had not been assessed appropriately. Recruitment processes were not robust with one member of staff providing independent support to people prior to their disclosure and barring service check (DBS) coming back. DBS is a check on people's suitability to work with vulnerable adults. It is possible to work before the full disclosure is received but this requires clear risk assessment, oversight and the agreement of people. This had not been put in place. Another person had not provided a complete employment history and this was evident as employer that provided their reference did not appear on their employment history. This anomaly had not been identified or addressed through appropriate recruitment processes. The registered manager told us following our inspection that these checks and risk assessments had been made.

These shortfalls were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had grown and there had been difficulties in ensuring all visits were covered. Whilst this had not resulted in missed visits, the registered manager was providing a lot of care and staff who had not completed their induction were providing unsupervised support and delivering care alongside other staff, as part of the care team rather than being supernumerary. We discussed this with the registered manager who acknowledged that they had not been able to maintain oversight during this time. The registered manager understood the need to halt growth of the company until appropriately recruited staff were employed.

Staff had not completed the provider's on-line training around safeguarding which meant they may miss some signs of potential abuse. However, they had discussed this with the registered manager and were able to explain the process of raising concerns and who they could report to. This training deficit was addressed immediately.

The systems in place to learn from incidents and accidents were not fully in use. The registered manager was aware that this work was ongoing.

Requires Improvement

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. No one was being deprived of their liberty at the time of our inspection.

Staff understood the importance of supporting people to make decisions and to check that they were consenting to care in a practical way at every interaction. They described the techniques they would use to encourage someone to have personal care if they were refusing their actions. However, they were clear if they could not persuade the person they would record and report their actions. Care delivery was not, however supported by documentation that reflected the MCA.

Where people potentially lacked capacity to consent to their care plan there was no evidence that an MCA assessment had taken place, or that their power of attorney had made this decision or that a Best Interests decision had been taken if necessary. The law requires this as protection for people who lack such capacity and to ensure that the least restrictive option is sought within care delivery.

We discussed this with the registered manager who told us they had signed up for independent guidance support that would provide them with paperwork to follow to ensure this statutory requirement was met. We were not able to assess the implementation of these measures at this inspection.

These shortfalls were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People was supported by staff who understood their care and support needs and spoke with respect about how they provided care. However, assessments did not always cover issues relating to equality and diversity or detailed information about people's preferences. As a result, people's care plans did not contain this guidance for staff to meet people's individual needs. Assessment and the resultant care plans should underpin respect for diversity to reduce the risk of staff not understanding people's wishes.

We recommend you seek appropriate guidance to ensure protected characteristics detailed in the Equalities Act are reflected in assessment and care planning.

Care plans did not all provide sufficient information for staff to support people's health needs. For example, one person's food and fluid were being monitored but there was no recorded information around target amounts for fluid and food to ensure they were not at risk of dehydration or malnutrition. Another person's weight was being monitored and there was no record of when their care plan should be reviewed in relation to this. Another person's care plan stated that they had arthritis but did not contain any information about how this impacted on their care other than they could not walk. There were no records of contact with health professionals available in the office. This meant that oversight of people's health needs was not robust.

These shortfalls were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection no one had a plan in place regarding risks associated with choking or aspiration. We were told by the registered manager that they would refer anyone who needed this specific support to appropriate health professionals. However, staff supporting people with food had not received training that would help them identify these risks.

Staff had access to online training and regular contact with the registered manager. Staff said they felt supported as result of this. One member of staff told us: "The support is great." Another member of staff explained: "I did a week of shadowing." A relative reflected they felt this to be the case telling us: "Without a doubt they have the skills they need." The care certificate was being introduced for staff who met the criteria. The care certificate is a nationally recognised programme that supports staff who are new to care to gain the skills and knowledge they need. The competency of staff was reviewed by the registered manager when they worked with staff. There was no formal process for recording this. There was a risk that staff who had not been assessed as competent were overseeing the practice of inexperienced staff. The registered manager told us they would address this.

Good

Is the service caring?

Our findings

People was supported by staff who knew them well and cared about them. Staff spoke with respect and kindness. People and relatives all commented on how kind and caring all the staff were. One person described the member of staff who visited them saying they had: "grown fond" of them. Another person described how they had felt unwell and staff had been particularly kind to them. The ethos of the service was to provide regular staff to ensure continuity of care and this was being achieved. People told us they saw the same care staff regularly.

Care and support plans focussed on enabling people to retain independence where possible and to remain living in their own homes. Care plans detailed how people communicated and identified any aids they needed to do so. People, and their relatives, felt they were able to communicate with the staff who supported them.

People told us they felt respected by staff and they did not have concerns about staff sharing their personal information.

Requires Improvement

Is the service responsive?

Our findings

The provider had not received any formal complaints. Relatives and people had access to the complaints process and there was a policy in place to ensure complaints were addressed appropriately. Most people and relatives told us they would feel able to raise concerns and complaints. One person, however, told us that whilst they liked the staff they did not feel listened to by the service. They told us that they had a reoccurring conversation with staff over regular late calls. Whilst this lateness fell within the time frames detailed by the provider the person felt their preference was not being heard and this impacted on their ability to live their life the way they wanted to.

People told us they received care that largely reflected their needs and their preferences. They told us the care provided was what they expected. One person told us: "I know they would change things if I wanted." Another person said: "I haven't seen the care plan but they do what I need." A relative told us that they felt the service were responding to their parents changing needs. Care plans had not been reviewed regularly and care delivery records were not available in the office. Five people had no daily records available in the office although they had all been using the service for more than three months. This meant the records had not been reviewed by senior staff and this meant the opportunity to ensure the quality of care or reflect changes appropriately was missed. Care plans did not always reflect the current care people received. For example, one person's care plan detailed less visits than they actually needed and received.

We discussed this with the registered manager. They explained they were introducing a new electronic care planning system and this would address many of the issues around care planning and recording. They also acknowledged that the care plans did not all contain personal detail and they had started to address this. Some care plans had been written or reviewed by experienced staff. The registered manager told us they planned to increase these roles. We saw that these care plans included personalised detail such as what elements of personal care people needed help with and the way they liked this to happen.

Communication styles were recorded in people's care plans. At the time of our inspection no one needed communication support as referenced in the Accessible Information Standard. This a standard set to ensure that people's communication needs are identified and responded to appropriately by services. The registered manager told us they would include this standard into their new care recording systems.

Requires Improvement

Is the service well-led?

Our findings

Obasan Services Limited is a family business set up in response to the family's own experience. The service had a clear ethos of ensuring only a small number of staff provided each person's care. Staff, people and relatives all understood this ethos and appreciated the benefits associated with it. However, Obasan Services Limited was a growing business and there were a number of risks involved in this approach. The providers did not have appropriate governance and quality assurance systems in place to identify, manage and mitigate these risks as the business grew.

The registered manager was the owner of the service. 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.
The registered manager knew the people using the service well. They provided care and worked alongside staff. People and their relatives commented on their approachability and were aware that the service was relatively new. This had not led to difficulties for most people who were pleased with the service they received. One person, however, told us they felt the service was unprofessional and had not taken on enough staff before taking on more people's care packages. One relative raised concerns about record keeping and oversight.

Governance and quality assurance systems to ensure safety had not been established or embedded. For example, the registered manager told us they looked at MAR records and checked staff competence. This had not been effective in protecting the person who had not received their pain relief correctly. We were told that care delivery records and MAR were brought to the office monthly to be reviewed but this was not the case. Issues identified during the inspection had been discussed during the registration process for the service. The registered manager had been clear during the registration process about how they would meet statutory requirements such as those outlined by the MCA and their oversight responsibilities.

These shortfalls were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood their responsibilities and knew who they could seek guidance from. They were proud of their work and made comments such as: "It is a lovely job". They said they felt listened to and supported by the registered manager. The registered manager spoke highly of their staff.

The registered manager explained the systems they were putting into place relating to personnel matters, care planning and delivery. They were aware of the issues of oversight and anticipated these systems making a difference to the quality of information they had quick access to.

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 11 HSCA RA Regulations 2014 Need for consent Care was not delivered within the framework of the MCA.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks people faced had not been reviewed and their care plans did not contain sufficient detail to ensure safe care and treatment. The risks impacting on people's care relating to staffing had not been considered sufficiently to ensure people's safety.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The oversight of people's care and treatment was not sufficient to ensure safety or to improve quality.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not robust. The risks associated with recruitment had not been sufficiently addressed.