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GTG Care Nursing - 112a Lichfield Street

Inspection report

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Date of inspection visit:
21 March 2016
22 March 2016
23 March 2016
24 March 2016

Date of publication:
17 August 2016

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?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 21 March 2016 and was announced. At the last inspection completed in January 2014 we found the provider was not meeting the regulations regarding assessing and monitoring the quality of the service and record keeping. At the most recent inspection completed in March 2016 we found the provider had not made the required improvements.

GTG Care Nursing is a domiciliary care agency registered to provide personal care and nursing care. We did not inspect the regulated activity of nursing care as there was no service being provided at the time of the inspection. At the time of the inspection the service was providing personal care support to 22 people living in their own homes. These people were mainly older people, some of whom were living with dementia. We confirmed with the registered manager that the regulated activity of nursing care was not currently being used by the provider, therefore, this regulated activity was not inspected. There was a registered manager in post. 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.

People were not always protected by a staff and management team who knew how to recognise and report signs of potential abuse. People were not protected by robust risk management processes. There were not robust systems in place to ensure people received the support they required to safely manage their medicines.

People were not protected by safe recruitment processes. Insufficient pre-employment checks were sometimes completed before staff members began work. The quality of service people received was often reduced due to insufficient staff levels.

People were not always supported by staff who had the appropriate skills to support them safely and effectively. People who had capacity to make decisions were supported to consent to their care. Where people lacked capacity decisions were not always made in line with the Mental Capacity Act 2005. Most people were supported to maintain their day to day health and received the support they wanted with their food and drink.

People felt most care staff were kind and caring although this was not consistent across the whole staff team; including management and office staff. People were supported to make day to day choices about their care and maintain their independence. People's privacy and dignity was protected and upheld.

People's care did not always meet their needs and preferences. People were not always involved in the planning of their care and regular reviews. People's complaints were not always recorded and responded to appropriately.

People were not protected by strong systems and quality assurance that identified potential risks and areas for improvement within the service. The registered manager had not developed a culture that accepted and recognised the shortfalls in the service and made clear plans to improve the service provided to people.

We found the provider was not meeting all of the regulations required by law. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

People were not always protected by a staff and management team who knew how to recognise and report signs of potential abuse. People were not protected by robust risk management processes.

Insufficient pre-employment checks were sometimes completed before staff members began work. The quality of service people received was often reduced due to insufficient staff levels.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported by staff who had the appropriate skills to support them safely and effectively. People who had capacity to make decisions were supported to consent to their care. Where people lacked capacity decisions were not always made in line with the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People felt most care staff were kind and caring although this was not consistent across the whole staff team; including management and office staff.

People were supported to make day to day choices about their care and maintain their independence. People's privacy and dignity was protected and upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care did not always meet their needs and preferences. People were not always involved in the planning of their care and regular reviews. People's complaints were not always recorded and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

People were not protected by strong systems and quality assurance that identified potential risks and areas for improvement within the service. The registered manager had not developed a culture that accepted and recognised the shortfalls in the service and made clear plans to improve the service provided to people.

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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 21 March 2016 and was announced. We gave the provider 48 hours' notice of the inspection because it is a domiciliary care agency and we needed to be sure that they would be in. The inspection team consisted of two inspectors, a Specialist Advisor 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. The specialist advisor was a qualified nurse who has experience working with older people.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We looked at the information the provider had sent to us in their Provider Information Return (PIR). A PIR is a document that we ask providers to complete to provide information about the service. We used this information to help us plan our inspection.

As part of the inspection we spoke with seven people who used the service and eleven relatives. We spoke with the registered manager, the assistant manager and nine members of staff including senior care staff and care staff. We also spoke with one health and social care professional. We reviewed five people's care records including their medicine administration records, four staff files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People were not protected by a staff and management team who knew how to recognise and respond to concerns about potential abuse. While most people told us they felt safe with staff, some people told us they had concerns about certain staff members working with people who needed the service. Not all staff we spoke with were able to describe the potential signs of abuse which could result in concerns not being recognised and reported. We spoke with the registered manager, assistant manager and a senior member of care staff about a specific safeguarding concern identified during the inspection. They had not recognised the concern as a safeguarding issue and had not reported the concern to the local safeguarding authority. We reported the concerns that we identified during the inspection directly to the local safeguarding authority. Staff and managers we spoke with were not able to demonstrate they knew how to identify and report safeguarding concerns about people.

We identified multiple safeguarding concerns during the inspection which had not been reported by the registered manager and as a result had not been investigated. We confirmed with the registered manager they had been made aware of several concerns. We reported multiple concerns during the inspection directly to the local authority for investigation. The registered manager had failed to ensure concerns about people were reported to the local authority. This resulted in investigations not being completed and plans to keep people safe where appropriate had not been implemented.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

People were not always protected by robust recruitment processes that ensured only appropriate staff members were recruited. Three of the four staff files we looked at did not have appropriate reference checks in place. We found multiple staff members were recruited with only personal references having been obtained, either from friends or family members. We found employment histories were not adequately checked. One reference had been obtained from a referee claiming to be the staff members previous employer. However, this employer had not been listed as part of the individuals employment history. The registered manager had not identified this discrepancy. We identified that one staff member's interview notes stated they had been unable to answer any of the interview questions sufficiently, however, the provider had proceeded with an offer of employment without further investigation or risk assessment. We also identified that some checks on staff member's potential criminal history had not been completed until after they had visited people in their homes. The registered manager had failed to ensure that sufficient pre-employment checks were completed to protect people from potential harm.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed.

We looked at how the registered manager was identifying and managing risks to people using the service. We saw risk assessments were completed that identified potential risks to people; such as if they were 'prone to falling'. However, we saw there were no identified measures as to how staff should keep people

safe and minimise risks to them. Care staff we spoke with were not always able to identify the risks to people and how to reduce the risk of potential harm to them. For example, one staff member was not able to describe how they would keep someone safe when using the hoist. Relatives of people using the service also told us staff did not know how to keep people safe when using hoists, therefore, they sometimes had to show care staff how to safely use the equipment. The registered manager had not ensured that staff had sufficient knowledge of potential risks to people and how to keep them safe.

When people had experienced an accident or had been involved in another adverse incident, they were not protected by systems that kept them safe. We found accidents and incidents were not recorded and the registered manager was not aware of serious events that had arisen. We spoke with the registered manager about incidents we were made aware of during the inspection, including one resulting in emergency services being contacted. The registered manager was not aware of the incidents and confirmed they had not been recorded. Staff we spoke with told us they recorded accidents and incidents in daily care records, however, they were not required to complete an accident record. The most recent accident record kept by the registered manager was dated six years ago. The registered manager had not ensured that accidents and incidents were recorded and reported to ensure appropriate actions were taken to keep people safe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Some people told us they received their care visits at the required time, however, most people said they did not. We received multiple complaints about the time at which people received their care visits. Some people told us issues with late and missed calls had improved within the last two months, however, many people told us they continued to have concerns. We looked at staff rotas and found multiple care visits had been scheduled for staff to attend at the same time. We spoke to the registered manager who told us they often attended care visits to resolve issues when 'double bookings' had been made. Relatives of people using the service told us they felt there were insufficient numbers of staff to cover calls. One relative told us, "It does seem like they're very short staffed". The registered manager confirmed they did not have sufficient staff at the time of the inspection. They told us they needed to recruit another six or seven staff members to resolve all of the issues with the rotas. They also told us they were having difficulties in recruiting suitable staff members. The quality of the service provided to people regarding the time at which they received their care visit had been compromised by insufficient numbers of care staff. This resulted in people not being sufficiently protected and always receiving their care visits when they needed them.

Most people told us they were happy with the support they received with their medicines. However, we found people were not protected by safe systems that ensured they received their medicines as prescribed. We found there were inadequate records kept that outlined which medicines staff should be administering to people and at what times. We identified some medicines that appeared not to have been given as prescribed by care staff from medicines administration records. The registered manager and assistant manager were not able to provide an explanation as they themselves were not aware if these medicines should be given. On further investigation they told us the medicines that appeared to have been missed had been self-administered by the people themselves. Care plans and medicines administration records did not sufficiently outline the support people required with their medicines. Care staff told us they would identify the medicines required by someone by looking at the medicines kept in people's homes, not from care planning information. We spoke to the registered manager about the checks they completed on people's medicines and the medicines administration records to ensure they received their medicines as prescribed. The registered manager confirmed they did not complete any checks. The registered manager had failed to ensure there were systems in place to ensure people received the support needed with their medicines.

Staff were not able to describe how they would keep someone safe if they identified they had not received or taken their required medication. We identified that not all staff had received appropriate training in medicines. The registered manager confirmed that while they provided basic training, they had no system in place to check the competency of staff to ensure they were administering people's medicines safely. The registered manager was not ensuring staff had the required skills to administer people's medicines safely and as prescribed.

Requires Improvement

Is the service effective?

Our findings

People told us care staff did not always have the required skills to support them effectively. One person said, "Some of the [care] staff I'd like to train myself". Some people and their relatives told us when care staff had visited them for some time they learned the skills needed, however, when new staff visited they were not able to do the job. One person's relative told us, "When the new ones come you have to show them what needs to be done. I had to explain how to put the sling on (for the hoist). You would have thought they would know what to do when they come". This relative told us, "They should be trained before they come here". Another relative told us when a new member of care staff visited, "I could have done the job quicker myself because it took me longer to show them what needs to be done." Staff members and the registered manager told us new care staff were required to 'shadow' more experienced care staff before they were able to begin working alone. Some people told us this happened but others said that new staff sometimes came, "Out of the blue" with no other care staff to support them. The registered manager told us their senior care staff completed spot checks on the quality of care provided by staff. However, we found these checks were not always effective and no checks were done to ensure senior care staff were themselves sufficiently competent to recognise skills gaps in care staff. The registered manager had not ensured staff had sufficient skills to support people effectively.

We looked at the training records provided by the registered manager. They told us training for care staff was renewed every three years. We identified from the training records some staff had received no training in certain key areas such as medicines administration. We identified other staff where training had been completed eight years ago and had not been renewed in line with the policy described by the registered manager. We were told by the assistant manager further training was being arranged for care staff in areas such as medicines administration. The registered manager had failed to ensure sufficient appropriate training was provided to care staff.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Staffing.

People who had capacity to make decisions around their care told us care staff always sought their consent before providing support. One person said, "They all ask me…even though most of them know how to do things". 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. We found the registered manager and the staff team had insufficient knowledge of the requirements of the MCA.

Despite being told by the registered manager that most people using the service had limited capacity to make decisions about their care, we found no assessments of capacity had been completed in line with the MCA. Decisions made on people's behalf about their care had not been made in their 'best interests' in line with the requirements of the law. Where consent to people's care had been taken from representatives, the

registered manager had not checked they had the appropriate legal authority to make decisions on people's behalf. One relative told us about an incident where care staff had proceeded with personal care against a person's wishes. The relative explained their family member's capacity could fluctuate on different days with their health needs. We were told they could hear their family member clearly saying 'no' to care staff. We spoke with the registered manager about this incident who confirmed they had spoken with the care staff concerned. However, they had not proceeded by following the principles of the MCA in ensuring future decisions about this aspect of care were made in the person's best interests. People's rights were not being upheld by the appropriate application of the Mental Capacity Act 2005.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for Consent.

Most people told us they were happy with the support they received with their food and drink. One person told us, "I am offered a good variety of meals and staff help me to eat and drink due to my condition". Many people told us they received support from family members with their meals. People were supported to eat and drink sufficiently when the service was required to assist them.

Most people told us their family members assisted them with day to day health needs and medical appointments. However, we were given examples from people where they had needed additional support from the service and this had been provided. One person told us how they had needed extra support in obtaining some cream from their GP and staff had supported them well. People's day to day health needs were met.

Requires Improvement

Is the service caring?

Our findings

People told us they felt most care staff were kind and caring in their approach while providing support. One person told us, "Carers always talk to you and have a laugh and a joke with you". Another person said staff were caring and "Very kind". A third person told us the care staff had a positive impact on their life and said, "It has made my life so much easier to know I am being looked after." People's relatives also told us they felt most staff were caring and they had positive working relationships. One relative told us, "We work together to make sure everything is done well". However, some people and their relatives did give examples of when care staff had not been so kind and caring in their approach. For example, we were told how some care staff were not always patient and gentle when supporting them to move. Several people and their relatives gave us examples of staff they felt were not appropriate to be working in a caring role with people. People also told us they felt communication from managers and the office was not conducted in a caring way. One person told us, "The carer lets the office know if she is going to be late but they don't always communicate it to me". A relative said, "They sent someone else instead. They didn't bother to tell you." People felt this lack of communication was not caring. Most care staff were kind and caring in their approach, however, this was not always consistent across the service.

Most people told us they were given day to day choices about their care. One person told us, "They even ask me what colour trousers I want to wear". We were given examples by people of the choices given by care staff, including how they wanted personal care to be done or what they wanted to eat and drink. Staff we spoke with were able to give examples of how they gave choices to people. One staff member told us, "[We] have to offer choice and see how much people can do for themselves." People also told us how care staff supported them in remaining independent. One relative explained how one person was able to remain living at home independently. Other people told us they were supported to do things for themselves where possible. People were given choices in their care and were supported to remain independent.

People also told us how care staff maintained their privacy and dignity while they provided care. Staff we spoke with were able to describe how they would protect people's privacy and dignity while they completed tasks such as personal care. One person's relative told us staff respected their choices around the gender of the care staff supporting their family member. They told us this was important in maintaining the person's dignity and helped them feel comfortable while they were receiving support. Another relative told us, "I think [care staff's name] is very good with [my relative]. This relative told us care staff protected privacy and dignity and "[They] seem to know [my relative] wants and needs." People's privacy and dignity was protected by care staff.

People were supported to have their relatives involved in their care package where they wanted this to happen. Relatives and other appropriate representatives were encouraged to become involved in communication with the service enabling people to receive additional support when required.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives gave us very mixed views around whether care provided met their needs and preferences. One person told us they had not seen a care plan but said, "[Staff] know what I like". Some people told us they were aware of their care plan and were involved in creating and developing the plan. One person told us, "They asked me questions about what was important to me". Another person told us they were having problems changing some information in their care plan. They told us, "I have left messages in the office four times but no one called back". A relative said, "There's nothing in the property that outlines clear instructions". Most people told us there was no formal process for developing care plans before care packages began. One relative told us, "Nobody from GTG has been out to complete an assessment or see [my relative]". Another relative told us they were required to give instructions to staff as they did not know what to do before they arrived. They told us, "In fairness when I give an instruction they do what I ask of them." We looked at people's care plans and found they indicated some preferences had been considered. For example, leaving a glass of water for someone and not putting pillows behind them. However, this was not consistent and we found not only did staff not always have a clear understanding of people's needs but care plans did not reflect their needs accurately. For example, the registered manager told us several people did not have dementia diagnosed formally. However, this conflicted with information provided to us by relatives and also information recorded in care plans. Care plans did not accurately contain important information such as what support people needed with their medicines, how to safely use equipment such as hoists or the time at which people wanted their care visits. We found staff and managers did not always know this information when it was not accurately recorded in care plans. People and their relatives were not involved in the planning of their care. The registered manager had failed to ensure the care delivered and people's care plans accurately reflected their needs and preferences.

We looked at how the registered manager reviewed people's packages of care and found there was no formal process. The registered manager gave us an example of how the provider had recently reviewed someone's care package with them and as a result had rewritten the care plan. However, after being unable to locate the care plan they confirmed the document had been lost therefore the revised care plan was not available to the person or the staff team who needed the new information. We were told by some relatives that documentation was not always clear. One relative told us, "There is a care plan in the house and there are records of the visits but you can't read what the records say". We spoke to the registered manager about how they ensured changes in people's needs were effectively communicated to the staff team and we were told they expected care staff to read care plans at the start of each care visit. We asked the registered manager if they felt this was effective considering the missing information we had identified in care plans and the quality of documentation we reviewed. The registered manager acknowledged these issues and told us they would review their processes. The registered manager had not ensured that reviews of people's care packages were effective and information about people's needs were available to the care team.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

We spoke to people about how they felt the service managed complaints and received mixed views. One

person gave us an example of a concern they had raised with management which they felt had been dealt with promptly and appropriately. Another person told us when they raised a complaint the immediate issue seemed to disappear but they were not kept informed of any actions taken by the registered manager. A relative told us about a concern they raised and said, "I'm not sure what action was taken when I complained to the manager". We looked at records kept by the manager and found they did not keep a written record of complaints and comments. We saw correspondence between the registered manager and one complainant and felt the response by the registered manager was not always appropriate. The registered manager had failed to ensure complaints were recorded and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found the provider was not meeting the regulations regarding assessing and monitoring the quality of the service provided to people and record keeping. The provider submitted an action plan which outlined how they intended to improve. At this inspection, we found the provider had failed to make the required improvements.

We identified during the inspection that the provider had failed to submit statutory notifications regarding significant incidents that had arisen in the service. For example, we identified allegations of abuse that we had not been notified about. A statutory notification is a notice informing CQC of significant events and is required by law. The registered manager was not aware of their legal obligations to report significant incidents to CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents

People were not protected by quality assurance and audit systems that identified risks within the service and areas for improvement. We looked at the quality assurance and audit systems completed and found them to be inadequate. We were told that audits of daily records were completed by senior care staff. However, there was no record of these audits and they had failed to identify the concerns we found during the inspection. We found that managers and senior care staff had not idenfied any of the issues we found during the inspection; including concerns with medicines management, care plans not identifying people's needs and staff being aware of how to meet people's needs safely. We confirmed with the registered manager no audits had been completed to check the quality of the service being provided. They told us they had weekly conversations with senior care staff and felt this had been sufficient. Despite numerous concerns being shared with us about the time at which people received their care visits the registered manager had failed to identify these issues. They had not completed any checks on rotas, daily records and staff timesheets. Several relatives told us care staff did not record the correct time of entry and exit into people's homes on daily records and there was no system in place to check these concerns. The registered manager had failed to ensure quality assurance systems were in place to effectively monitor the the service and respond to issues and concerns. People's safety was not protected and the quality of their care had been compromised.

We spoke to the registered manager about performance concerns relating to a staff member. They told us they had a system to ensure the staff member only attended accompanied care visits with other staff members. We identified several instances through staff rotas where the person had been working alone. The registered manager told us this was an error and confirmed they had no robust system in place to ensure this staff member did not work alone. We also confirmed with the registered manager they had no system in place to check the competency of staff members in their role in specific areas such as medicines administration. The registered manager was not ensuring there were effective systems in place to ensure staff were competent in their role and people were protected from potential harm.

During the inspection we were told that new policies and procedures were in place. When we highlighted concerns around the content of the provider's medicines policy the registered manager asked us to review their old policy instead. They could not be clear which policy was in operation. We found shortfalls in other areas such as the provider's safeguarding policy which did not sufficiently outline how to recognise and report concerns about people. This is an area in which we found multiple concerns within the service. The provider did not have clear and safe systems of work in place. Policies and procedures were not robust and understood by staff member's. Their policies and procedures did not ensure the safe operation of the service and were not protecting people from the risk of potential harm.

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

While most people gave us positive feedback about their care staff, we received mixed feedback about the management and office staff. People did not always feel they were communicated with in a positive way. One person told us, "The office say they will call back but they never do". One relative told us, "[The registered manager] thinks they're managing the service, but [they're] not." They said, "The communication is terrible. Absolutely terrible." Most staff told us they felt management were supportive. One member of staff told us, "I am very happy with this company. I get support from the manager and we have meetings to talk about things." We found the registered manager had not developed an open culture that supported and drove improvements within the service. We found the registered manager did not always take responsibility for the shortfalls in the service.

A new assistant manager had been recruited into the service several weeks prior to the inspection. The registered manager told us they wanted this new manager to take over the day to day responsibility of running the service. We found this new manager to be committed and saw they took steps immediately following the inspection to begin making the required improvements.

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 People were not involved in the development of their care plans and care did not always meet their needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's human rights were not protected by the effective implementation of the Mental Capacity Act 2005 when making decisions on people's behalf about their care.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always effectively identified and managed in order to protect them from harm.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected by a staff and management team who could recognise signs of abuse and took appropriate steps to safeguard them from potential harm.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected by quality assurance processes that identified and rectified areas of improvement and concern within the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected by safe recruitment processes that ensured only appropriate staff members were recruited.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by staff members who had been given the skills to support them effectively.