Special Seven Limited

Special Seven Care (Beds)

Inspection report

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Date of inspection visit:
19 December 2017
20 December 2017
21 December 2017
22 December 2017

Date of publication:
08 February 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 20 February 2017. After that inspection we received concerns in relation to the recruitment of staff, the management of people's medicines and safeguarding concerns. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Special Seven Care (Beds) on our website at www.cqc.org.uk.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults.

The service had a registered manager. 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.

Staff did not always administer medication in a safe manner and follow best practice guidelines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have effective recruitment processes to verify that the people being employed were fit and properly qualified to undertake the role. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

They had insufficient staff available to support people safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The services quality monitoring processes were ineffective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This is the first time the service has been rated requires improvement.

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?

Inadequate

The service was not always safe.

The provider had not ensured proper and safe use of medicines.

There were systems, processes and practices in place to safeguard people from harm but these were not effective.

There was insufficient numbers of suitable staff to support people to stay safe and meet their needs.

When errors were made by the provider or staff, these were not always acted on, lessons learned and improvements were not made.

Is the service well-led?

Requires Improvement

The service was not Well-led

There was not always a consistent approach to record keeping.

There was a lack of governance framework and staff did not always understand their responsibilities in relation to quality performance, risks and regulatory requirements.

The service did not learn, improve and ensure sustainability.

Special Seven Care (Beds)

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 checked 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 19 December 2017 and was unannounced.

Inspection site visit activity started on 19 December 2017 and ended on 22 December 2017. The inspection team consisted of one inspector from the Care Quality Commission.

Before the inspection we reviewed information we held about the service, including the notifications they had sent us. A notification is information about important events which the provider is required to send to us. We also reviewed information that had been sent to us from the local authority and members of the public.

During the inspection, we spoke with the registered manager, the recruitment manager, two care staff members and the office administrator. We also spoke with four people who used the service. We spoke with two people's relatives. We also spoke with the local authority commissioning team.

We looked at the care records of five people who used the service and the recruitment and training records for six staff employed by the service. We also reviewed the medicine records for 10 people using the service.

Inadequate

Is the service safe?

Our findings

The provider was unable to ensure that staff supported people to receive medicines in a safe and effective manner.

We reviewed the Medication Administration Records (MAR) for ten people who used the service. We saw that for the months of October, November and December 2017, most charts contained errors which were not explained. For example, for one person we saw that staff had signed to say that they had supported the person with their medicines on 31st November 2017, which we pointed out was not a day as 30 November was the last day of the month. We also saw that there were gaps within charts which could not be explained. For example, on 26 October 2017and 30 November two medicines were not provided. For a second person, medicines were missed on 03 November. For another person we saw that for weekends there were mainly gaps. We asked the registered manager why this was and they explained that the person had requested that weekend visits be stopped. However we saw that on some weekends staff has signed to say that medicines had been given. The registered manager was unable to explain why these entries were in the charts.

We also found that where a person was required to have eye drops administered twice daily, staff had not recorded this on a person's chart. Again we asked the manager why this had happened. They told us that the person's family would order new medicines for the person and the person had run out of medicine. This however had not been recorded. Another person required cream to be applied for pressure areas. We noted that on 14 November 2017, staff had not recorded if they had applied the cream during the morning or evening calls. On the 28 November we also saw that the tea time and bedtime records had not been completed.

We saw that the registered manager was carrying out audits of the medicine records and these were improving slightly but there was no accountability for staff failure to support people in a safe manner. We also saw that where the manager had carried out audits they would also miss errors, which should have been picked up easily. For example on one person's record it clearly stated that the medicine was to be taken in the morning. We noted that for September, October and November the medicine was administered during the evening call. This had not been picked up by the registered manager in any of the audits they had completed. We raised this with the registered manager who explained that the person's medicine had been changed to evenings and this was why they were given the medicines at that time. We asked the manager that if this was the case then why had they not changed the instructions on the MAR chart to reflect the actual instructions given by the doctor. The registered manager could not explain this.

The lack of accountability and the failure to follow basic procedures in the safe administration of medicines meant that people were not provided with medicines in a safe manner.

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

The service did not ensure that there was sufficient numbers of suitable staff to support people to stay safe

and to meet their needs. People we spoke with also did not feel that there was sufficient staff available to support them. We spoke with a person who required two staff to support them. They told us, "I don't always get two of them. One will come and if they need help they will call the other one, you see the other one will go and catch-up with the other calls if they are behind." Due to the persons assessed care needs this person was required to receive two to one care in order to keep them safe, but this was not happening. We checked the rota for the person and noted that two staff had been allocated to them. This meant that the rota provided was not a true representation of the support being provided by service. We also received information from another person's relative who stated that their relative was scheduled to receive half hour calls but that staff would only stay for 10 to 15 minutes. A third person we spoke with told us, "They are very late; I never know when they are coming. Yesterday it was 8am and today it was after 10. I can't get out of bed without them and it's not nice having to lie in bed waiting especially if I am wet."

We reviewed the rota provided by the office administrator and found that there were gaps in the allocation of staff for the week of our inspection. We also found that a person had been scheduled in for a carer to support them in the morning and the evening. However when we called the person we were told that they did not receive any support through special seven care (Beds) at those times. We reviewed the rota provided again and found that the person had been scheduled in for two care calls daily over a number of weeks. This again showed that the rota was not a true reflection of the care being provided.

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

The provider did not have effective systems, processes and practices in place to safeguard people from abuse. When we reviewed staff folders we found that the provider had not carried out sufficient checks on staff to ensure they were fit to work with vulnerable people. Staff had been allowed to work with people even though Disclosure and Barring Service (DBS) checks had not been completed. For example we saw that one member of staff had been employed with the service for several months but their DBS checks had not been requested until December 2017. This person had been supporting people. We raised this with the registered manager who told us that they would not allow this person to support people until their DBS checks had returned.

Risks to people were assessed through risk assessments and these were present in people's care plans. However the personalised risk assessments were ineffective because in reality the provider was not supporting people in line with their assessed and agreed support needs. This was because although risk assessments and care plans stated people required two carers to support them, the provider was not in practice always providing this care. This was confirmed by the people we spoke with.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post but the registered manager was unable to maintain the standards of care required to support people. We found that on the day of our inspection the registered manager was out of the office attending calls and the staff in the office were unable to provide us with information we required in a timely manner. When we attended the offices on the day of our inspection we were met by an administrator who told us that the registered manager would usually be out of the office for the mornings supporting people with calls and would return later in the day. This person had no access to any files of documents relating to Special Seven Care (Beds). While we were at the offices they had to call other people in order to obtain passwords and access codes for computer systems and filing cabinets.

We eventually we were met by a member of staff who was able to provide us with information about staffing and recruitment. We were also able to gain access to people's care documents.

We asked to look at the recruitment records for staff employed by the service. We saw that one person had provided two references. These had been completed on the official headed paper for another care provider. We looked at the person's application and checked it against the references received. We asked the recruitment staff member if these were personal or employer references. They told us that they believed they were employment references because the person had stated that they had worked for that provider named on the letter head. We further reviewed the person's application and noted that they had stated that they only worked for that provider for a matter of weeks. On further inspection we also found that both people had provided personal addresses within the reference and had stated that they were friends. We pointed this out to the recruitment staff member who was unaware of this. We also further highlighted to them that the contact addresses provided by both people were the same address as the member of staff. We asked the recruitment staff if they had verified the references and they confirmed that they had contacted the mobile numbers provided on the reference and not the company telephone number on the reference form. This meant that they had not correctly verified the reference and could not confirm if it was genuine.

We reviewed another member of staff's references and again found discrepancies. This person had provided information on their application of their most recent employer who was a care agency local to the providers address. However, for the purpose of references the member of staff provided another agency which was located in the Bedfordshire area. We asked the recruitment staff why there was no reference from the person's last employer but they were unable to confirm the reason for not applying for it. We also saw that the reference they had received from the provider in Bedfordshire was a private e-mail address for a European country and not a company address. Again we asked the recruitment staff why they had not picked up on this and they could not confirm. For another member of staff we also saw that they had stated that they had gained their experience and qualifications from a hospital in Europe. We asked the recruitment staff if they had approached the hospital to verify the person. They told us that they were unable to find that specific hospital when they tried to search for it. Therefore there was no reference from them. This showed that the provider did not have effective recruitment processes in place to verify that the people being employed were fit a properly qualified to undertake the role.

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

The registered manager's quality assurance systems were ineffective and did not ensure that the quality of the service provided was adequate. Although we saw that the manager had audits in place, we did however find that inconsistency in completing documentation was not picked up within the audits. For example, although the registered manager carried out monthly medicine audits errors were still wide spread. We also found that spot checks were carried out but again the manager had not picked up on staff not attending calls for the correct durations and where staff were required to support people in pairs this was not always happening. The registered manager had also not ensured that recruitment processes had been followed which meant that they could not be sure that the staff they had recruited had the skills required to support people.

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

From discussions with the registered manager we found that they had identified that they were struggling to maintain quality of care in the current climate. They told us that they had recently lost staff and were therefore struggling to provide people with the agreed support. We were told that they would be reducing the number of packages and this was also confirmed by the local authority. The registered manager said, "I have expanded too quickly. I know that I cannot keep all the packages so I have asked for them to be taken back." The registered manager acknowledged that when we inspected them in February 2017 the service was good. The registered manager said, "I want to go back to the size I was then. It was manageable, I know that now." They went on to say, "I have not recruited the right people, I have to make sure that I recruit the right people in the future, it's been a hard lesson." The manager had a clear vision on how to return the service back to a good service and was looking to learn from the mistakes that had been made. We found throughout our inspection that people who used the service felt that staff were caring and kind towards them. They did however all feel that in recent months the quality of the service had deteriorated.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not provided with medicines in a safe manner.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager's quality assurance systems were ineffective and did not ensure that the quality of the service provided was adequate.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have effective recruitment processes in place to verify that the people being employed were fit a properly qualified to undertake the role.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was not sufficient staff available to support people safely.