Essence (Telford) Ltd

Essence Telford Ltd

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Essence Telford Ltd is a domiciliary care service that provides personal care to people living in their own homes. At the time of our inspection visit, the service was providing personal care support to four people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service
People did not receive safe care or support as the processes, systems and managerial oversite was ineffective. Staff were not safely recruited or sufficiently trained to safely support people. People were not safeguarding from the risks of abuse or ill-treatment as the management team failed to follow locally agreed protocols for reporting concerns. People did not receive safe support with their medicines as the staff had not been trained or assessed as competent before supporting them. The management team failed to complete accurate guidelines for the safe administration of medicines.

The service was not well-led. The management team did not have effective quality monitoring systems in place to identify or respond to poor care, poor record management or inadequate risk assessments. The management team failed to provide evidence they were competent to effectively assess risks of potential harm or complete care and support plans. The provider failed to notify us of key events which they are required to do by law.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection and update.
The last rating for this service was Good (published 7th November 2018).

Why we inspected
The inspection was prompted in part due to concerns received about staffing, safety and the management of the service. A decision was made for us to inspect and examine those risks.

This report only covers our findings in relation to the Key Questions Safe and Well-led.

The ratings from the previous comprehensive inspection for the other key questions were not looked at on this occasion but were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Essence Telford Ltd on our website at www.cqc.org.uk.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

Enforcement.
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to keeping people safe, staff recruitment and training, safeguarding people from abuse, quality monitoring and reporting significant incidents.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Essence Telford Ltd

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 conducted by two inspectors.

Service and service type
Essence Telford Ltd 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 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
The inspection was announced 48 hours before the visit. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.
Inspection activity started on 5th August 2020 and ended on 7th August 2020. We visited the office location on 6th August 2020.

What we did before the inspection
We contacted the local authority and Healthwatch for feedback about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 this information to plan our inspection.

During the inspection
We spoke to three staff members, the registered manager and the nominated individual. We spoke with one person using the service and three relatives. We looked at two peoples care and support plans. We looked at four staff files in relation to recruitment and training. In addition, we looked at a variety of documents relating to the management of the service, including policies, procedures and any quality checks they completed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• People and relatives indicated they felt safe whilst receiving services. However, Essence Care Telford Ltd did not undertake accurate nor specific risk assessment in order to keep people safe from harm. For example, with the providers risk of scalds or burns states "Staff must ensure that the water is warm…" Neither the registered manager nor the nominated individual understood what a safe water temperature was. Thermometers were not provided to test the safe temperatures and there were no instructions to staff members on how to keep people safe.
• Risk assessments were generic. One person's risk assessment contained the name of a different person throughout. We asked the registered manager and the nominated about this risk assessment and it was clear the assessment was not specific to the person's needs. For example, one section stated how to prepare and serve food when the provider did not complete this specific task for this individual.
• Risk assessments stated a full fire risk assessment was completed in relation to people's properties. We asked the registered manager and the nominated individual for a copy and they confirmed they told us they didn't do any. The registered manager went on to say these assessments, "Sort of stopped."
• There was a lack of other risk assessments, including but not limited to, risk falls, tissue management or the risk from dehydration or malnutrition.
• These issues put people at risk of harm as reasonable measures were not in place to minimise the potential for injury.

Using medicines safely
• People did not receive their medicines safely.
• None of the staff members employed by Essence Care Telford Ltd had been trained or assessed as competent to safely support people with their medicines despite staff undertaking this role. At the time of this inspection and in agreement with local commissioners Essence Care Telford Ltd was in the process of removing this support for people.
• We looked at people's medication and administration records (MAR'S). These did not indicate what the medicine was for, how much or any specific side effects. Neither the registered manager nor the nominated individual understood what individual medicines were. We asked the nominated individual about one person's specific medicine as they supported this person the most. They told us the person did not have paracetamols despite this being included on the MARs records and in the hand-written notes. We asked to see the PRN (As required) guidance for this medicine. There was no indication of when to take this medicine, how much, the gaps between doses or the maximin amount in 24 hours.

• This put people at risk of harm as they were supported by untrained staff who did not know how to safely support them with their medicines.

Learning lessons when things go wrong
• Although the provider had systems in place to record incidents, accidents and/or dangerous occurrences these were not used effectively. For example, following one person being found on the floor the provider did not complete a falls risk assessment to prevent the risk of future incidents. accidents or to minimise the potential for harm.
• The provider did have a disciplinary process in place.

These issues were a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• The provider did not have the systems and processes in place to safeguard people. For example, concerns had been raised with the provider regarding the potential abuse of one person. The provider failed to report these concerns using the locally agreed protocols for reporting suspected abuse.
• Staff members had not received training on how to report concerns. However, one staff member told us they would report anything to the registered manager and if nothing happened, they would contact the local authority.

These issues were 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 did not follow safe recruitment processes when employing new staff members. For example, we saw staff members had been employed without Essence Care Telford Ltd checking their Disclosure and Barring Service Check (DBS). DBS information assists employers make decisions about the suitability of staff members. A further example was one staff member was employed by the provider in 2018 and their right to work check list was only completed in July 2020.
• The provider failed to check gaps in people's applications. For example, one person had a gap in their employment history of over 20 years. The provider could not evidence what they had done to satisfy themselves this gap in employment was safe before making an employment decision.
• The provider failed to check people's references consistently at the point of recruitment. For example, we saw evidence on staff members files of letters of introduction they had brought with them at interview. The provider could not evidence they had checked the authenticity of these documents.
• Staff members were expected by the provider to support people without receiving training or an introduction to their role. For example, we saw one recently recruited staff member. They had not received an introduction to their role, basic training like moving and handling or first aid and had not been assessed by the provider as competent to support people.
• The provider failed to deploy suitably qualified, competent and experienced staff to enable them to meet the needs of people.

Preventing and controlling infection
• People and relatives told us staff members used appropriate personal protective equipment. However, the registered manager told us none of their staff members had been trained in preventing or controlling the risk of infection.

These issues were a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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. Continuous learning and improving care

• The provider did not have effective quality systems in place to ensure the safe provision of care for people. For example, they failed to identify or act on staff training deficits, concerns with medicines, lack of safeguarding notifications and lack of environmental risk assessments for people.

• The nominated individual did complete sporadic "spot checks" with some staff members, but not all. These checks included if the staff member arrived on time and they spoke with the person appropriately. However, where an action was required, they did not specify what was needed or when. For example, one check indicated the staff member needed additional training. It did not specify what training or how this was going to be provided.

• None of those receiving care services, nor their relatives, had been asked by the provider for feedback on the service they received. The nominated individual told us they used to do these but had since, "Taken their eye off the ball." The provider did not have effective systems for managing the quality of service they provided.

• The provider failed to demonstrate an understanding of risk and complete the necessary checks on staff suitability but also on legal requirements. For example, the provider used their vehicle to support people, to make care calls and to transfer staff members to the place of work. They failed to ensure vehicles used were appropriately insured and their use lawful. The provider told us they didn't know about this and would check with their insurance company.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• All those we spoke with told us they didn't know who the key personal within Essence Telford Limited were. One relative said, "I don't know who they are really. I have just been plonked with them. They just turned up on day one with no introduction or anything."

• Care and support plans, along with risk assessments, were generic and not specific to the person they related too. People and relatives told us they were not asked for their input into the care and support they received. The provider did not have systems in place to get feedback or suggestions from people regarding the support they received.

• People and relatives told us they never received any information from the provider. This included any

changes as a result of the Covid 19 Pandemic. One relative said, "I have had nothing from them (provider). I don't know if they have changed anything or if they are just carrying on as normal."
• Staff members told us they received only minimal information from the provider. None of those we spoke with had been informed of anything different in terms of the Covid 19 Pandemic. We asked the provider about this and they told us they talk to staff but didn't routinely send them out information or check their understanding.
• When we checked the providers website and although it was displaying the correct rating for their location it also stated they had been rated as outstanding by the CQC and they were an award-winning care provider. We asked the provider about this and they confirmed they were not an award-winning care provider and they had never been awarded a rating of outstanding. The registered manager committed to amending this to ensure members of the public received factually accurate information.

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 did not understand their responsibility in being open and honest when something goes wrong. They failed to notify us and the local authority of significant incidents using the recognised and locally agreed processes. In addition, they failed to complete effective investigations when the conduct of their staff members was questioned.
Working in partnership with others
• From the information we looked at there was no evidence the provider effectively worked in partnership with others. For example, the provider supported people with specific medical conditions. The provider did not engage with specialists or seek specific advice or guidance when they created or revised the care and support plans.

These issues constitute a breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• The provider did not fully understand the roles and requirement of their registration with the Care Quality Commission. This included submitting notifications to the CQC regarding certain incidents and events. At this inspection we found three examples where we would expect the provider to have informed us of certain events. For example, safeguarding concerns.

These concerns were a breach of Regulation 18: (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009.

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 did not notify us of significant events.

The enforcement action we took:

We continue to work with the Local Authority to safeguard people.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care or support as the processes, systems and managerial oversite was ineffective.

The enforcement action we took:

We continue to work with the Local Authority to ensure people are safeguarded.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding concerns were not acted on appropriately.

The enforcement action we took:

We continue to work with the Local Authority to safeguard people.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provided did not have systems in place to ensure people received good care.

The enforcement action we took:

We continue to work with the Local Authority to safeguard people.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

Staff were not safely recruited or suitably trained.

The enforcement action we took:

We continue to work with the Local Authority to safeguard people.