Grace Care/Training Limited

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Inspection report

Basildon Enterprise Centre
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Essex
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Grace Care/Training Limited provides a domiciliary care service and is registered to deliver personal care to people in their own homes.

The focussed inspection was unannounced and took place on 7 July 2016. The registered manager was in the process of deregistering with the Commission as they no longer worked at 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.

Previously we carried out an announced comprehensive inspection of the service on 5 May 2016 and found that nine legal requirements had been breached. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Grace Care training Limited on our website at www.cqc.org.uk

Following the inspection, we requested that they provided an action plan setting out what they would do to meet the legal requirements and we imposed conditions on their registration with us.

We undertook this focussed inspection to check that the provider had followed their action plan to meet the legal requirements. We found at this inspection that the provider had not taken the necessary action and were not meeting the requirements.

The service did not have appropriate systems in place to protect people from harm. Staff recruitment processes were not robust and the necessary checks had not been undertaken to ensure staff had been recruited safely.

Risks to people's health and wellbeing were not appropriately mitigated and managed. People did not get their nutritional needs met to keep them well as visits to people were missed or late.

The safe management of medicines was not in place with the required checks about the competence of staff skills and abilities to assist people with their medicines.

Staff did not receive the required induction, training, supervision and support to undertake their role.

There was not sufficient leadership of the service in place. Quality assurance and management systems were not developed to monitor the care provided to people who used the service.

People's views were not taken into account and used to make improvements to the service. Processes were not in place to deal with people's complaints and concerns.

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.

Staff had not been recruited safely with the necessary checks in place.

Systems were not in place to protect people from harm.

Risk assessments were not robust enough to protect people from harm.

The safe management of medicines was not in place.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive the support and training they needed to carry out their role effectively.

Supervision and checks on staff were not in place to monitor their capability and understanding of the tasks they were required to undertake.

People's capacity was not assessed in order to support them in making decisions for themselves.

People's health and nutritional needs were not met by staff in a timely way.

Is the service caring?

Inadequate

The service was not caring.

The service did not respect people wishes and preferences

Staff did not always treat people with respect and dignity.

Is the service responsive?

Inadequate

The service was not responsive.

People's choices were not respected and their preferences were not taken into account by staff providing care and support.

Care plans contained information related to people's needs and wishes but were not being met in a timely way.

Is the service well-led?

Inadequate

The service was not well led.

There was insufficient leadership and financial security of the service.

Quality assurance systems were not in place to monitor the care provided to people who used the service.

People's views were not utilised to make improvements to the service.

Grace Care/Training 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.

We undertook a focussed unannounced inspection on 7 July 2016 with one inspector.

Previously we had carried out an announced comprehensive inspection of the service on 5 May 2016 and found that nine legal requirements had been breached. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Grace Care training Limited on our website at www.cqc.org.uk.

Following the inspection on 5 May 2016, we requested that they provided an action plan setting out what they would do to meet the legal requirements and we imposed conditions on their registration with us.

Before the inspection, we looked at information as to the provider's activities and their improvements and adherence with the conditions imposed upon them. We reviewed any complaints, safeguarding concerns and intelligence provided to us about the service.

On the day of our inspection, there were 10 people using the service, six care staff and three management staff. We met with the acting manager and the care coordinator.

We reviewed five people's care records, six staff recruitment and training files and looked at quality audit records such as policy and procedures. We did not seek the views of people and their families on this occasion as the local authority was involved and talking with them and their families directly.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Grace Care Training Ltd on 5 May 2016 we found that suitable arrangements had not been put in place to ensure that people were safe. This was because staff were not safely recruited, risk assessments had not been completed and medicine management systems were not in place. This meant people were placed at risk of not receiving safe care and treatment. This was a breach of Regulation 12 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We carried out this focussed inspection on 7 July 2016 to check they had followed their action plan provided to us on 14 May 2016.

We looked at the recruitment process for employing staff to work at Grace Care Training Ltd. We found that the required checks were not in place and little improvement had been made to ensure that people employed were suitable and safe to work with people who used the service.

Employment application forms were not completed appropriately. Gaps in employment were unaccounted for and had not been verified in four of the recruitment files we looked at. Therefore, we could not be assured that there were genuine reasons for their previous unemployment.

Staff had been employed to provide care and support to people without the service requesting, receiving and recording confirmation of a clear Disclosure and Barring Service (DBS) check. One staff did not have a DBS check on file and four DBS checks were not in the name of the company and no update service check was on the file to show they were cleared and safe to work with people in the community. The staff found with convictions at the last inspection were no longer working for the service.

The references that we saw had been completed electronically which did not ensure they were authentic. The person's identity and their conduct had not been checked and verified prior to employment being offered and work commencing. This was in direct contravention of their recruitment policy which stated 'This reference is invalid if no official company stamp or compliment slip were provided.'

In one staff member's file, we saw that their permission to work in the UK had expired in July 2015. We saw from the rota that they were still working on a full time basis. The acting manager told us that the staff member was awaiting confirmation of their ability to work in the UK but they had not provided any evidence to support this. After our inspection, action was taken to remove the person from the rota so that they were not working with vulnerable people until proper checks had been completed and appropriate information received.

This is a breach of Regulation 19 of the HSCA 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

The provider's safeguarding policy and procedure had not been reviewed or updated. Staff did not have up to date guidance to follow so that they were knowledgeable and aware of the signs of actual or possible

abuse.

We were told in the action plan given to us by the provider that a designated staff member would be taking responsibility for overseeing safeguarding in the service. However, the training for this role had not been looked into as the provider did not have the funds to pay for it.

Safeguarding systems and processes were not in place and operating effectively to prevent people from being placed at risk. People using and relying on the service were put at risk when missed calls took place. One person who was reliant on the service to provide them with all their personal care and assistance with meals and had no capacity to make any decisions around their daily needs experienced neglect. They were placed at serious risk of harm as checks were not in place to ensure that care was being provided.

This is a breach of Regulation 13(2) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

Improvements had been made to the risk assessment process. In the five care files we looked at, risk assessments had been completed. This contained information about the person's mobility, falls, medicines, skin care and the equipment they used. However, there was insufficient and unclear information about managing these risks, how to mitigate them and what staff should do about them to keep people safe. For example, in the care plan for one person, it was recorded that they had a pressure sore under their stomach. In another person's care plan, it was recorded that they were at high risk of a pressure sore and that they had a sore on their leg and bottom. There was no information recorded about what care and treatment or action was to be taken to care for either person's skin effectively.

In the care plan for another person, it said that they were epileptic, but no information as to what to do if the person had a seizure was available to staff. Staff would not know how to provide safe care and treatment to people who used the service. Whilst risk assessments had been reviewed, they did not provide sufficient information and understanding for staff in order that people's health and wellbeing was maintained.

This is a breach of Regulation 12 (1)(2)(a)(b) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Staff had access to people's homes through a key safe system if they lived alone. Key safe information was kept confidential and separate from the care plan and given out to staff as and when necessary. However, the acting manager told us that the staff did not have identity badges when they were visiting people in their homes. They did not have any other form of identification available to them other than their T shirt uniform to show who they worked for. People were at risk of harm as they could be letting unauthorised people into their homes.

We saw that some improvements had been made to the management of medicines. These included the introduction of a Medicine Administration Record (MAR) to be completed and kept in each person's folder at their home, details of people's medicines and if they self-administered their medicines or needed prompting or assistance with it. This recorded information provided clear instructions to staff about where the medicine was being kept, the description of it, dosage directions, purpose, the colour of each tablet and the prescription.

The service's medicine administration policy and procedure had not been updated despite the acting manager showing us some training slides about medicine management which they had put together for a training session on 29 June 2016. They told us that they had given staff a copy of these slides as guidance in

their work. However, they were not robust enough to provide staff with a clear authorised process to follow to administer medicines to people safely.

Safeguarding concerns relating to missed calls and medicine errors had been investigated and classed as substantiated by the local authority. A system to improve the monitoring of calls to people, especially those who required medicines, had been put in place but missed and late visits to people continued to place them at risk of harm of not receiving their medicines appropriately because they had not received agreed visits from staff to provide them with the care they needed within the appropriate time-frame.

No checks on staff competence in assisting people with their medicines or completing the new MAR sheets had been done to see if this system was working for people.

This is a breach of Regulation 12 (1)(2)(g) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safe care and treatment

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection of Grace Care Training Ltd on 5 May 2016 we found that suitable arrangements were not in place for people to receive effective care and support. This was because the service did not provide staff with the necessary skills, knowledge and supervision to carry out their role and people's nutrition and hydration needs were not being met. This was a breach of Regulations 11, 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We carried out this focussed inspection to check they had followed their action plan provided to us on 14 May 2016.

The service had made little improvement in its system for supporting and training its staff. The acting manager told us that four training dates had been set up in June 2016 to ensure that all staff could attend and this would cover medicine awareness, safeguarding, code of conduct, record keeping and staff development. Only one of these training sessions was held as the acting manager told us that staff had not turned up to the other three sessions. The session was for two hours. Two existing staff and two potential new staff attended the session.

The process for checking the competence of staff in undertaking their duties had been put in place. We saw that one staff member had been assessed during their work and this showed that they were competent in aspects of infection control, assisting with medicines and health and safety.

Whilst it had been identified that management staff required training in medicine administration and managing the safeguarding process within the service, this training had not been completed. We were not satisfied that staff were sufficiently trained and knowledgeable to carry out these roles effectively and keep people safe from harm.

This is a breach of Regulation 18(2)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

No care or management staff had undertaken training in understanding the MCA 2005 and how this related to people's freedoms and rights to make choices and decisions for themselves. The care plans had described people as having 'mixed dementia' and memory loss but not how to address these needs. At the

time of the reviews of people care and support, they or their representative, (usually a family member) had signed to say they had consented to their care and support arrangements. However, we did not see any assessments in relation to a person's capacity to make their own decisions, where this may affect their health and wellbeing especially in relation to medicines and identified risks.

This is a breach of Regulation 11(1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Need for consent.

Very little information about people's nutritional and dietary needs was contained in any of the care plans we saw. From the limited training records, no staff had undertaken training in food hygiene.

We saw from information taken from the database system that people were not having their meals and drinks as assessed and in a timely way. Staff were arriving late for their calls and some calls were being missed completely leaving people at risk. We saw that from 6 June to 27 June 2016, there were seven late calls either at breakfast or lunchtime and six missed calls, three at breakfast time, two at lunch time and one at tea time.

It was recorded that for one person, the late calls may have had an "adverse effect on their health because they were diabetic and they attempted to prepare their meal but overcooked the food due to dementia." For another person, where calls were missed at breakfast, lunch and tea time all on one day, they had to make alternative arrangements and go to a relative's house to have a meal.

We could not be assured that the service was effective in meeting the nutritional or hydration needs of people who used the service as part of the arrangements made for the provision of their care.

This is a breach of Regulation 14(1)(b) of the HSCA 2008 (Regulated Activities) Regulations 2014, Meeting nutritional and hydration needs.

It was noted that people's healthcare needs were met by professionals. For example, one person, who had a high risk of falls, had a physiotherapist involved in supporting them to use equipment. People had assistance at home from the district nursing service and this was recorded in the person's care plan.

Inadequate

Is the service caring?

Our findings

At our comprehensive inspection of Grace Care Training Ltd on 5 May 2016 we found that staff were not showing consideration and caring for people in delivering their care arrangements. This was a breach of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We carried out this focussed inspection to check they had followed their action plan provided to us on 14 May 2016.

We gathered the views and experiences of people who used the service from the complaints and information about the service we had received. Generally, people said that the staff were kind and respectful and caring towards them. However, the amount of late and missed calls with little or no communication about why they had left people without a service or provided a service that was not at a suitable time for them showed that the service was not caring in its approach or delivery of care.

There had been some improvement in the use of language in the writing of most of the care plans so that it was more person centred. The care plans explained about people's needs and recorded their wishes and preferences to show they had been included. Most of the daily notes we saw were written in a respectful way and explained clearly what tasks had been completed and how the person was feeling.

However, we saw some daily notes for one person that recorded on three different days in the same week that the person was feeling unwell and complaining of pain. There was nothing written after this to say what action had been taken except that the staff member had recorded on each day that they, "Washed the plates and tidied up the room." This did not show that the staff member was being understanding of the person's feelings, or responding appropriately to them in a respectful way. We spoke with the acting manager about this to ascertain what action had been taken. They were unaware of the situation or the content of the daily notes we showed them.

We were not assured that action had been taken to provide this person with assurance, pain relief or to seek medical assistance.

This is a breach of Regulation 10(1) of the HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

Inadequate

Is the service responsive?

Our findings

At our comprehensive inspection of Grace Care Training Ltd on 5 May 2016 we found that people's needs were not being assessed, care plans not being written in a person centred way, rota arrangements not in place and complaints not being dealt with. This is a breach of Regulation 9 1)(b)(c)(3)(a)(b) and 16 of the HSCA 2008 (Regulated Activities) Regulations 2014, Person-centred care and Receiving and acting on complaints.

We carried out this focussed inspection to check they had followed their action plan provided to us on 14 May 2016.

Improvements had been made to the care planning and reviewing process. Reviews had been completed with the involvement of people and their families on all but one care plan at the time of the inspection. The acting manager told us that completing this task had given them a better understanding of people's needs and circumstances and how they could meet them in a more person centred way.

The content and quality of the assessments provided clearer and more accurate information about people's needs. Whilst the hand written assessments at the home were signed at the time by those present, the care plans to go back to the persons home were typed up so they were legible. Information included activities of daily living, the details of the personal care required, duties and tasks to be undertaken, use of equipment and the times and frequency of the calls required. Details of people's medicines and if they self-administered it or not was clearly recorded. This provided staff with an understanding of the medicines people took and their preferences and wishes. Staff would be able to respond to people's needs as up to date information about them was available.

There was little information about people's ethnicity, faith or religion, sexual orientation or choice about gender specific care identified in any of the care files we saw. However, some information had been included about people's likes and interests such as, "Likes to go to snooker once a week." And, "Likes TV, football and lap top."

A daily notes book was used to record the tasks and activities undertaken for the person and to share any information of importance such as changes to the care plan. We saw copies of some of the completed daily notes. Staff varied in the way they responded in writing to the time spent with people. For example, some wrote factual details about the outcome of the visit and tasks completed whilst others wrote about the person themselves such as, "Seems in good spirits".

We asked to see improvements to the way in which staff were allocated to people who used the service on a day to day/weekly basis. The new database system Malinko had been established to provide a weekly rota and we were given a copy of this. It identified where staff were at what times and when two staff were needed to assist people. We were told by the acting manager that this was given to staff on a weekly basis at the moment as there were a lot of changes taking place to the numbers of people being cared for. However, despite the development of a new rota, staff were not responding to people's needs in a timely and

organised way as missed and late calls were still happening and people were not receiving a service to which they were entitled.

This is a breach of Regulation 9(1)(a)(b) of the HSCA 2008 (Regulated Activities) Regulations 2014, Person-centred care.

Some improvements had been made to the receiving and logging of complaints. We saw from information taken from the Malinko software system that people's concerns, incidents and missed or late calls had been logged and the immediate action taken. We asked to see records of the outcome of these complaints but the acting manager told us that there was little written correspondence or any written apology to people who used the service or their relatives. We did not see any information that showed that the service responded routinely to and used the complaints and concerns as an opportunity to learn and improve the service.

This is a breach of Regulation 16 of the HSCA 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection of Grace Care Training Ltd on 5 May 2016 we found that the provider was not meeting this regulation because they were not managing the day to day service and providing effective management for people who used the service and the staff. This was a breach of Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f) of the HSCA 2008 (Regulated Activities) Regulations 2014, Good governance.

We carried out this focussed inspection to check they had followed their action plan provided to us on 14 May 2016.

Following the resignation of the registered manager, an acting manager had been appointed to oversee and manage the service. The acting manager was not able to make all the necessary improvements on the action plan due in part to their lack of knowledge and expertise in health and social care and the lack of finances available to make the necessary improvements. We had also found that a lack of financial management had caused the service to have cash flow problems as the service had not invoiced the local authority for services provided to people. This meant that staff had not been paid for the work they had undertaken for the service.

The service had not improved its quality assurance system as the necessary improvements to the safe recruitment of staff, their supervision, training and support had not been done. No training had been undertaken by any staff members in the mandatory subjects necessary to support them in their role. Only one staff member had had their skills and knowledge checked in order that the management knew that one staff member was competent to be providing care for people.

None of the service's policies and procedures had been reviewed or updated. We asked to see the medicine administration policy as the process had been set up and we were told by the acting manager that this had been implemented and was being undertaken by staff. The medicine policy was written on one page and the acting manager had not reviewed this as part of the medicine administration procedure. This meant that staff were not working to an agreed set of rules and principles of practice.

The database system was being used to record all complaints, incidents, missed and late calls and communication with people who used the service. However, this was not being used to manage the service effectively and assess and prioritise improvements which were needed. The acting manager was not aware that they needed to make statutory notifications to CQC about suspected or actual abuse or harm to people. There was no overall process in place to regularly seek the views of people. The views of people who used the service had been sought as part of the reviews but the service had not been developed with people's input or involvement or learning from their complaints or compliments.

No actions were in place to deal with the catalogue of missed and late calls and the harmful effect this had on people who used the service. People were not provided with a personalised service that was responsive to their needs and which supported and maintained their autonomy and independence.

This is a breach of Regulation 17 (1)(2)(a)(b)(e)(f) of the HSCA 2008 (Regulated Activities) Regulations 2014, Good governance.

The service had made some improvements in terms of undertaking reviews of people's care needs and risk assessments and recording their prescribed medicine arrangements. Some health and safety and risks within the environment of people's homes were now recorded in order that staff could keep people they cared for and themselves safe.

People's care records were in order, kept confidential and accessible upon request.

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 9 HSCA RA Regulations 2014 Person-centred care The provider was not meeting this regulation as people were not receiving care which met their individual needs and in a way they wanted. This is a breach of Regulation 9(1)(a)(b) of the HSCA 2008 (Regulated Activities) Regulations 2014, Person centred care.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider was not meeting this regulation as people were sometimes not treated with dignity and respect in the delivery of their care arrangements. This is a breach of Regulation 10(1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not meeting this regulation as people's capacity to make their own decisions had not been assessed and recorded. This is a breach of Regulation 11(1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Need for consent

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation

Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not meeting this regulation because the management of risks to people's health and wellbeing was insufficient to keep them safe. This is a breach of Regulation 12(1)(2)(b)(c)(g) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safe care and treatment

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not meeting this regulation as systems were not in place to keep people safe from harm. This is a breach of Regulation 13(1)(2)(c)(d) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider was not meeting this regulation because people were not getting their nutrition and hydration needs met. This is a breach of Regulation 14(1)(b) of the HSCA 2008 (Regulated Activities) Regulations 2014, Meeting nutritional and hydration needs.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider was not meeting this regulation because they were not receiving and acting on complaints appropriately. Regulation 16(1)(2) of

	the HSCA 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not meeting this regulation because they were not managing the day to day service and providing good governance for people who used the service and the staff. Regulation 17(1)(2)(a)(b)(e)(f) of the HSCA 2008 (Regulated Activities) Regulations 2014 Good governance

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider was not meeting this regulation as the staff were not recruited safely and in line with current requirements. Regulation 19(1)(a)(3)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not meeting this regulation as staff did not have the skills and abilities to care for people safely. Regulation 18(2)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing

The enforcement action we took:

Cancellation of registration