Olive Care Limited

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Inspection report

Regent House
Bath Avenue
Wolverhampton
West Midlands
WV1 4EG

Date of inspection visit:
28 May 2019
29 May 2019
30 May 2019
03 June 2019

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

Summary of findings

Overall summary

About the service: Olive Care Limited is a domiciliary care agency that provides personal care to people living in their own homes. At the time of the inspection the service provided support to three older people.

People's experience of using this service:

People were not protected from the risk of abuse due to the provider's failure to develop robust safeguarding systems. People were also not protected from the risk of harm due to inadequate risk management systems. People did not always receive their medicines as prescribed.

People were supported by sufficient numbers of care staff. However, the timing of care visits was not consistent. Care staff were not always recruited safely. The provider had not ensured that checks such as references and checks on staff member's criminal history were in place prior to staff supporting people.

People were not supported by a staff team who had the skills and knowledge to support people safely. People's right's were not always upheld by the effective use of the Mental Capacity Act 2005. People's nutritional needs were not always fully understood and met safely. People were not supported to maintain their health needs.

People were supported by a staff team who they had a good rapport with and felt were concerned about their needs. Care staff were keen to support people in a caring way but had not been given the skills and knowledge required to identify when care practices were not caring and dignified.

People did not always receive care and support that was personalised to their needs and planned in line with current legislation and guidance.

People felt they could raise complaints however we found concerns about the timing of care visits had not been addressed.

People were not supported by a service with effective management and governance systems in place. The provider had not ensured that areas of improvement required and risks to people were identified. Where concerns had been raised by third party organisations, the provider had failed to take proactive action to ensure improvements were made. The provider's failure to identify areas of concern and to make appropriate improvements exposed people to the ongoing risk of avoidable harm.
Rating at last inspection: This was the first inspection of this service since it was registered with CQC on 01 June 2018.

Why we inspected: This was a scheduled inspection based on the registration date of the service.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found in

inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Olive Care Limited

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was completed by an inspector, an assistant inspector 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.

Service and service type:
This service is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older adults; some of whom are living with dementia.

The service had a manager registered with the Care Quality Commission. This means that 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:
We gave the service over 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 28 May 2019 and ended on 03 June 2019. We visited the office location on 30 May 2019 to see the manager and office staff; and to review care records and policies and procedures.

What we did:
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 reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with two of the three people who used the service. We spoke with the provider who was also the registered manager and five of the six staff members the provider informed us were employed at the time of the inspection. We reviewed records relating to three people's care records, their medicines and records relating to the management of the service; including staff recruitment records, complaints and quality assurance records. We also reviewed information about a serious safeguarding incident relating to two staff member's being convicted of theft from a person who had been using the service.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- A serious allegation of abuse had been made that had resulted in the conviction of two staff members for theft from a person who had been using the service. As a result, we looked at the provider's processes and systems for protecting people from abuse and found they were inadequate.
- Staff we spoke with were not able to outline how they would identify signs of potential abuse. We also identified safeguarding concerns recorded within daily care records that had not been recognised as potential indications of abuse by either care staff or management. As a result no action had been taken to protect people from the risk of ongoing harm.
- We looked at the provider's safeguarding policy and found despite it having been recently reviewed it was not in line with current legislation.
- The provider told us they were completing more frequent spot checks on care staff to ensure early concerns about staff conduct could be identified. When we looked at the spot checks we found this was not the case. Some staff had received only one check since 01 January 2019 while one staff member had not been checked at all.

The provider's failure to ensure people were sufficiently protected from the risk of abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding people from abuse and improper treatment

Using medicines safely

- People were not receiving their medicines as prescribed due to inadequate medicines management systems being in operation.
- We found from reviewing people's medicines administration records and their daily care notes that people were not always receiving medicines as prescribed. For example; one person's records showed they had not received multiple doses of medicines that were critical to their health. We found where these concerns were identified, the provider had failed to ensure appropriate healthcare professionals were informed. Therefore action was not taken to protect the person from any harm that may arise to them due to not having their medicines.
- Where people did not receive medicines due to the availability of stock we also found the provider failed to ensure action was taken to inform appropriate parties so medicines could be made available to people.
- We found recordings of medicines administration were inadequate. We found medicines administration records (MARs) did not contain full and accurate information about people's medicines as required by current guidance. We also found where topical creams were being administered this was not always recorded.

The provider's failure to ensure people received their medicines safely and prescribed was a breach of

regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and treatment

Assessing risk, safety monitoring and management
• The provider had failed to ensure that risks to people were appropriately assessed and documented. For example, we found examples of where risk assessments were not reflective of current equipment in use or specific risks to people while staff were supporting them to move.
• Care staff we spoke with were not always aware of people's health conditions; for example, one person using the service was living with diabetes. Staff were not aware of the symptoms they needed to monitor for individual people to ensure they were not at risk of harm.
• We found insufficient monitoring of risk to people. This resulted in the provider not taking sufficient action to protect people as new risks were emerging or existing conditions posed an increasing risk to people. Care staff and management were failing to recognise the significance of specific risks to people. For example; in one person's care records care staff had recorded the person complained of being unwell, they displayed specific physical symptoms and also damage to their skin without any action being taken to protect them from harm.

The provider's failure to ensure risks to people were understood, monitored and mitigated against was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Staffing and recruitment
• Sufficient numbers of care staff were in post to ensure that all required care visits were carried out. However, one family we spoke with told us that care visits did not always happen at the times agreed and required. Records showed staff were travelling over 20 miles to calls as the provider had not recruited local care staff. We found the arrival time for one person's morning care visit varied in one month by two hours and 40 minutes. The provider confirmed they did not have systems in place to monitor people's call times to ensure they were not put at risk by the large variance in arrival times.
• We found the provider had failed to ensure that care staff were recruited safely. While we saw some pre-employment checks had been completed this was not consistent. We found one staff member had worked with vulnerable people and the provider held no record of checks including their employment history and reference checks.
• We also found the provider was not able to provide evidence of Disclosure and Barring Service (DBS) certificates for five current staff members. This was despite the provider being given four additional days following the site visit to obtain and forward this information to CQC, which they failed to do.
• We asked the provider for records of recruitment checks completed for the two staff members convicted of theft. The provider told us these records were not available to view as they were held by the police, however, the police informed us this was not the case. The provider was not able to evidence they had completed appropriate recruitment checks prior to these staff members working with vulnerable people.

The provider's failure to ensure appropriate pre-employment checks were completed for staff members was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed

Learning lessons when things go wrong
• The provider failed to learn lessons from significant events that arose within the service. For example; we found following the incident that led to the conviction of two staff members, the provider had failed to make adequate improvements to protect people from future harm. They had failed to ensure their safeguarding

procedures were reflective of current legislation and they had failed to make improvements to recruitment and staff monitoring systems.
• We identified further concerns that the provider failed to identify and learn from; including issues with people's medicines and people reporting potential safeguarding concerns.

The provider's failure to ensure their systems and processes were reviewed and improved following incidents of concern formed part of a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Preventing and controlling infection
• People told us staff observed good standards of hygiene while supporting them with personal care.
• Staff we spoke with told us they understood the need to use appropriate Personal Protective Equipment (PPE), including gloves and aprons, while supporting people.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- The provider had failed to ensure people's needs were appropriately assessed. Where people's needs had changed they had failed to ensure care plans were reviewed and updated in line with their changing needs.
- The provider was not aware of current standards, guidance and regulation. As a result, they had not ensured care was delivered in line with expected standards. For example; the provider was not aware of the latest NICE guidance around managing medicines in social care and we identified unsafe practices within medicines management systems.

Staff support: induction, training, skills and experience
- One person felt the staff had the required training and skills to support people while another did not.
- We found care staff we spoke with did not have the knowledge required to support people effectively and safely. For example, we found concerns in the knowledge of care staff in multiple areas including safeguarding and the management of risk to people.
- We identified discrepancies between what staff told us and training records. For example; staff members told us they had not received medicines training yet records were in place that said they had. Neither the staff members or the provider could give an explanation for this.

Supporting people to eat and drink enough to maintain a balanced diet
- People told us they were happy with the support they received with food and drink.
- We identified some concerns in staff knowledge around how to protect them from any risks related to their nutritional intake. For example, staff were not aware of who had diabetes and we identified a concern where one person did not have sufficient food in their property and staff failed to take appropriate action.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- We found staff did not always recognise healthcare concerns were a risk to people and as a result healthcare professionals and other agencies were not always informed to ensure timely interventions.
- We identified concerns with people's skin integrity and health were recorded in daily care records without healthcare professionals or named social workers being informed. As a result people were exposed to the risk of avoidable harm.

Ensuring consent to care and treatment in line with law and guidance
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 checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- The provider was unaware of the requirements of the MCA and how they were required to support people in line with the legislation.
- While people using the service had capacity to make most decisions about their care, we found examples of where the provider had not fully considered how they should use the MCA to ensure people's rights were upheld. For example; the provider did not recognise decisions they had made about one person's continence wear should have been considered in line with the requirements of the law.
- We also found where there were concerns about people's capacity this had not always been identified. As a result, the provider had failed to recognise where people may need best interests decisions making in line with the legislation. For example; where people were failing to remember to make contact with healthcare professionals and their health was deteriorating, the provider failed to assess the person's capacity and take appropriate action as required by the MCA.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
- One person told us that all staff were kind and caring. The second person told us, "Some [staff] are gentler than others but there are no problems."
- Most people told us care staff were kind towards them while providing care and that they had a good rapport with the staff supporting them.
- Care staff we spoke with seemed concerned about the wellbeing of the people they supported. They were keen to ask questions and raise concerns where they felt it would benefit the people they provided care to.
- The provider however, had not themselves developed systems within the service that ensured people were always well treated. They had not ensured care practice was sufficiently monitored to enable concerns to be identified. They had not equipped staff with the skills and knowledge needed to identify when care practice may not be caring.

Respecting and promoting people's privacy, dignity and independence
- People told us care staff protected their dignity while supporting them with personal care.
- One person told us they had raised concerns about the gender of the care staff supporting them although this had been addressed by the provider and was now resolved.
- The provider had not ensured that people were always referred to in a respectful and dignified way. For example; we saw examples of where care staff had referred to incontinence wear within daily care records as people wearing 'nappies'. The provider had reviewed these records and had failed to recognised this language was not supportive of the promotion of people's dignity.

Supporting people to express their views and be involved in making decisions about their care
- People told us the care staff sought their views and opinions and they were involved in decision making.
- People who required support to make decisions had appropriate representatives in place to provide guidance and to speak on their behalf when needed.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
- People told us the care and support provided met their needs; although concerns were raised around call times not meeting their needs. People told us call times could vary on a day to day basis and we confirmed this was the case from reviewing care records.
- People told us the timing of calls had an impact on their ability to make plans around the rest of their day and could result in some calls being too close together. The provider had not identified this was an issue and had taken no corrective action.
- Care staff we spoke with were aware of some of the needs of people they supported. However, we found they were not always aware of specific health conditions or risks they should be supporting people to manage.
- People told us they were aware of their care plan. One person told us, "The care plan is written in each time the staff are here".
- Care plans were in place but were not being effectively updated in line with people's changing needs.

Improving care quality in response to complaints or concerns
- People told us they felt able to raise complaints or concerns if needed.
- People told us about concerns that had been raised; including around the gender of care staff and call times. We were told the issues with the gender of staff had been resolved but concerns around call times had not.
- The provider told us they had not received any complaints since the service had started, which was not in line with the feedback we received from people using the service.

End of life care and support
- At the time of the inspection nobody using the service was in need of end of life care and support.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care

- The provider had failed to develop an effective quality assurance and governance system that identified areas of risk and improvement needed within the service.
- We found the provider had a system of reviewing care records including daily care records and medicines administration records (MAR). However, the provider had not been using their own system and these records had not been reviewed for a two month period at the time of the inspection. This meant they had not identified issues with the care quality during this period of time, including, the concerns we identified with the timing of care visits.
- We found where the provider had completed document reviews each month; they had failed to recognise where areas of risk were presenting to people. This included concerns about people's health and the failure to administer medicines as prescribed. As a result, the provider had taken no action to protect people and had exposed them to the ongoing risk of harm.
- The provider told us they were completing more frequent spot checks on care staff following the serious allegation of abuse that resulted in the conviction of two staff members. When we reviewed the records of these spot checks we found this not to be the case. One staff member had not received a spot check since January 2019 and several staff had only been checked once in the five months leading up to the inspection.
- The provider was not completing any further quality checks within the service.
- We found the provider was failing to ensure that records in the service were full and accurate. For example; we found medicines administraton records were not completed in line with national guidance and we found the administration of people's creams had not been recorded. We also found care plans and risk assessments were not always up to date and clearly outlining people's needs and risks to them.

The provider's failure to ensure effective quality assurance and governance systems were in place was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had failed to submit statutory notifications to CQC. A statutory notification informs CQC about significant events such as safeguarding concerns and serious injuries.
- The provider had not notified CQC about the allegation of financial abuse that resulted in the conviction of two members of staff.
- We identified further safeguarding concerns during the inspection that had not been identified by the

provider and notified to CQC.

The provider's failure to submit statutory notifications was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2008 Notification of other incidents

•□We found the provider was not effectively planning and promoting high-quality care. Despite having received feedback from external professionals about quality concerns within the service, they failed to take responsibility for the failings within the service and to make required improvements.
•□We found the provider was not receptive to feedback given during the inspection and did not take responsibility for the areas of the service that required improvement. They did not recognise their role and responsibility for the overall performance of the organisation and compliance with legal requirements.
•□We found the provider gave us information about areas of concern within the service that was not in line with documentation we saw and what external agencies told us.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•□People told us they felt the care staff working with them listened to their views and opinions. However, we found these were not consistently acted upon in all circumstances. For example we found ongoing concerns with the timing of one person's care visits.
•□People told us they felt the management listened to them but that they were 'under pressure' and in 'crisis'. They felt this may impact on their ability to take action needed.

Working in partnership with others
•□The provider failed to work effectively with external organisations and agencies. Health and social care professionals were not contacted proactively. Where the provider was in contact with professionals they did not communicate openly and transparently and failed to take on board feedback around quality issues within the service.