Mrs Elise Law-Kwang

L K Recruitment Limited

Inspection report

1555 London Road
London
SW16 4LF

Tel: 02086797499
Website: www.lk-recruitment.co.uk

Date of inspection visit:
21 September 2017

Date of publication:
02 July 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 21 September 2017 and was announced.

The service is a domiciliary care agency which provides personal care to people in their own homes. People received support through scheduled visits. At the time of our inspection there were 53 people using the service.

At our previous inspection in May 2016 we found breaches of the regulations in relation to the arrangements in place to ensure people received their medicines safely, how the provider supported its staff through training and appraisal and the systems in place to assess and monitor the quality of care people received. The overall rating for the service was, "requires improvement." We asked the provider to tell us how and when they would make the required improvements. Some of these actions have been completed. However the provider had not made improvements to the systems in place to assess and monitor the quality of care people received.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Registered providers must notify the CQC about certain changes, events and incidents that affect their service or the people who use it. The provider did not notify CQC of notifiable events such as allegations of abuse. This meant the CQC did not have full oversight of the risks associated with the service.

People told us that staff were regularly late and did not stay for the time allotted. People also told us they had experienced missed visits. This meant that care was not always delivered in accordance with people's care plans.

Staff knew how to recognise abuse and report any concerns. Risk assessments were carried out to evaluate any risks to the person using the service. Where risks were identified, risk management plans were in place for staff to follow.

People told us the staff were caring and treated them with respect. People were involved in planning their care and were asked for their consent before care was provided. Staff understood the main principles of the Mental Capacity Act 2005 and how it applied to people in their care.

People were supported to have a sufficient amount to eat and drink which minimised the risk of malnutrition and dehydration. Staff liaised well with external healthcare providers which assisted people to maintain their health. People told us they received their medicines as prescribed.

The provider did not have an effective system in place to receive, respond to and learn from complaints from people or their advocates. The system in place did not allow for complaints made over the telephone to be recorded, investigated and responded to.

Staff were recruited using an effective procedure which was consistently applied. Staff were appropriately supported by the provider through training, supervision and appraisal. However, staff did not feel listened to by the provider and staff morale was low.

There were a variety of systems in place to assess and monitor the quality of care people received. However these were not always effective in identifying areas which required improvement. Where the provider was aware that an area of the service required improvement they did not always take action to make the required improvements.

We found breaches of the regulations in relation to the provider's failure to protect people from neglect, the provider's failure to notify the CQC of notifiable events and the lack of effective systems to handle complaints and to assess and monitor the quality of care people received. You can see what action we asked the provider to take at the back of the full version of this report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Staff were often late to support people and this impacted the quality of care people received.

Risks to people were assessed and staff had guidance on how to manage the risks identified

Staff were recruited using an appropriate recruitment process which was consistently applied.

Medicines were effectively managed.

Is the service effective?

Good

The service was effective.

Staff had the skills, knowledge and experience to deliver the care people required. Staff were appropriately supported by the provider to carry out their roles effectively through induction, relevant training, supervision and appraisal.

Staff understood the main provisions of the Mental Capacity Act 2005 and how it applied to people in their care.

People who required it were supported to have a sufficient amount to eat and drink.

Is the service caring?

Good

The service was caring.

Staff were caring and treated people with respect.

People were supported by staff to be as independent as they could and wanted to be. People were involved in their care planning and in making decisions about their care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The provider did not have an appropriate system for handling people's complaints.

People's care plans were up to date and reflected their preferences for how they were supported.

Care plans were reviewed regularly. Staff knew people well and how to meet their individual needs.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The systems in place to assess and monitor the quality of care people received were not as effective as they needed to be. Staff morale was low and they did not feel listened to.

The provider failed to submit statutory notifications to the CQC.

L K Recruitment 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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was conducted by a single inspector who visited L K Recruitment offices on 21 September 2017. The provider was given 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure that the registered manager would be available to speak to us.

Before the inspection, we reviewed all the information we held about the service. This included registration information as well as routine notifications and safeguarding records. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually 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.

During the inspection we spoke with the registered manager, deputy manager, care co-ordinator and office manager. We looked at six people's care files and five staff files which included their recruitment, training, supervision and appraisal records. We also reviewed the systems in place to assess and monitor the quality of care people received.

After the inspection we spoke to six people who use the service, two relatives and six staff members.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in May 2016, we found there was insufficient information in people's care files to enable staff to support people to take their medicines safely; there was no information on the medicines people were required to take.

During this inspection we found that people's care files had relevant information on the medicines they were required to take including the dosage and the reason the medicines had been prescribed. Staff had received training in the safe administration of medicines. Staff were required to complete a record each time they administered a person's medicines. We checked these records and found gaps in the recording. We raised this with the registered manager who told us they were confident that people received their medicines safely but that staff sometimes forgot to complete the medicine administration records. People told us they received their medicines as prescribed although one person told us they sometimes received their medicine later than stated in their care plan.

People did not always feel safe using the service. This was because staff frequently arrived late and did not stay for the time allocated. This meant that care was not always delivered in accordance with people's care plan which put their health and welfare at risk. Relatives told us, "They often arrive late. I wouldn't mind if it was by five or ten minutes but sometimes they are over an hour late. This upsets [the person]. They don't want to be left in their soiled clothes waiting for the carers to arrive." and "Lateness is particularly bad at the weekends." People commented, "They are always late so they're not able to complete the job. I don't get to eat until they arrive which means that I take my medication late. I think this is affecting my health", "Sometimes they've been up to 90 minutes late and there have been times when they haven't turned up at all" and "My main issue with this agency is that the carers do not turn up on time. They either turn up too early or too late." Two people we spoke with had not experienced any missed calls or staff arriving late. They told us, "Their time-keeping is fine" and "They are usually on time."

Staff told us they were often late for visits. Staff members commented, "I am sometimes on the rota to be at three different people's homes at the same time. Obviously I can't be in three places at once so I'm bound to be late and that has a knock on effect. I've spoken to the office about it so many times but they don't care", "The office don't leave enough time between calls so I'm often running late. It's not fair on the clients", "I do my best but sometimes it isn't possible to get to the next client on time" and "There is a problem with us being late. Clients have complained about it and so have we but nothing has changed." One staff member told us they did not consider there was an issue with staff being late. The provider told us that a new system had been introduced by a local authority which commissions the service which would assist them to monitor staff punctuality. However, we remain concerned that people placed by other local authorities will be at risk of their needs being neglected because the provider does not have suitable systems in place to ensure staff arrive at people's homes on time.

Staff frequently arriving at people's homes late and missing calls meant that people's needs were being neglected. This amounts to a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider ensured staff received safeguarding training. They knew how to recognise the signs of abuse and report their concerns. There were safeguarding and whistle-blowing policies in place with which staff were familiar.

People's individual risks in relation to their environment and specific health conditions were assessed and recorded. Risk assessments covered areas such as people's mobility, skin integrity or manual handling needs. Staff were aware of the risks people faced; they told us there was sufficient information in people's care plans to enable them to manage the risks people faced.

The number of staff required to deliver care to people safely was assessed when people first began to use the service and also when a change in their need was identified. Records confirmed that the number of staff a person required to provide care was supplied according to their assessment. People told us they received care and support from the right number of staff. Where two staff members were required to support a person safely, people told us they arrived at the same time and worked together well.

The provider operated safe recruitment practices and appropriate checks were carried out before staff were allowed to work with people alone. Records indicated that the provider's recruitment practices were consistently applied. Staff were only recruited after an interview to assess their suitability for the role, receipt of satisfactory references, proof of identity and the right to work in the UK and criminal record checks had been carried out. Staff were also required to complete a health questionnaire which enabled the provider to check that they were physically and mentally fit to care for people. This minimised the risk of people being cared for by staff who were unsuitable for the role.

Good

Is the service effective?

Our findings

At our previous inspection in May 2016 we found that the provider was in breach of the regulations which required them to support staff through regular, relevant training and annual performance review.

During this inspection we saw evidence that since our last inspection staff had received training in topics and areas relevant to their work. This included moving and handling people and protecting people from abuse. Staff said the training they received was useful as it helped them to perform their roles better and had improved their knowledge and understanding of how to meet people's needs. The provider monitored training so that refresher training could be arranged when required to ensure staff knowledge and skills remained up to date. People felt that staff had the necessary skills to support them effectively.

Records indicated that since our last inspection staff who had worked for the service for more than one year had attended a performance review. Staff received support from the provider through one-to-one supervision meetings and staff meetings. These meetings provided staff opportunities to discuss their work performance, reflect on their practice and identify areas where they could develop further. One staff member had requested a refresher of their moving and handling training and we saw that this was arranged.

When first employed, staff received an induction during which they were introduced to the provider's policies, they received training in areas relevant to their role such as infection control and they were made aware of emergency procedures.

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. The registered manager told us that when they had concerns regarding a person's ability to make a decision, their family members and health and social care professionals would be involved in making decisions on their behalf and in their 'best interests' in line with the MCA.

Not all staff had received recent training in the MCA. However, the staff we spoke with (including some who had not received MCA training) understood the main principles of the MCA and knew how it applied to people in their care. Staff told us of the importance of allowing people to make their own decisions and the action they would take if they felt a person lacked capacity to make a particular decision.

People were encouraged to eat and drink sufficient amounts to meet their needs, where the service was responsible for this. Staff obtained information from people and their relatives about their dietary needs and how they wished to be supported with this. This information was documented in people's care plans, as well

as how people preferred their meals to be prepared. Where appropriate, staff recorded how they supported people with their meals. These records indicated the meals prepared by staff were based on people's specific preferences and choices. For example, one person's care plan stated that they liked tea and toast for breakfast; records of care completed by staff indicated that this was provided to the person.

People's care files contained details of their GP and other healthcare professionals involved in their care. People's care files contained relevant information for staff about the support they needed to manage their health conditions. Where appropriate staff liaised with external healthcare professionals to help maintain people's health. For example, we saw that staff contacted a person's care manager and GP when they had concerns about the person's weight loss.

Good

Is the service caring?

Our findings

People complimented the caring attitude of staff. People commented, "They are always respectful and willing to do whatever I ask", "The carers are helpful but sometimes seem a bit stressed and in a hurry" and "They are nice enough." However a relative told us that some staff could make more of an effort to speak to the person when they were providing support with personal care.

The staff we spoke with were enthusiastic about supporting people. Staff commented, "I enjoy my job", "I treat people the way I would like to be treated" and "I like helping people." We asked staff how they ensured people's privacy was protected and their dignity maintained. Staff responded, "I keep the bathroom or bedroom door closed and support them to do what they can for themselves", "I make sure they only take off the clothes they have to" and "I'll ask for permission to enter their room and always ask for their consent." People told us their privacy and dignity were respected. However a relative told us that staff being late to provide personal care sometimes meant their family member's dignity was compromised.

People were involved in planning their care and in how their care was provided. One person told us, "I spoke to them about what I need them to do and that's what they do." Another person commented, "They do as I ask and if I need to change anything I let them know. They are quite good like that."

The provider ensured people were given information to help them understand the care and support choices available to them before they started using the service. People told us they had been given a booklet which helped them understand what they could expect from the agency. People knew how they could make contact with the office staff and registered manager. They knew who to speak to at the service's office if they wanted to discuss their care plan or make a change to it.

People were supported to be as independent as they could and wanted to be. Care plans contained information about people's level of dependency. Staff were encouraged to prompt people to do as much for themselves as they could to enable them to retain control and independence over their lives. For example, although most people were prompted or assisted to take their prescribed medicines when they needed them, people who were willing and capable of managing their own medicines safely were actively encouraged to continue doing so.

Requires Improvement

Is the service responsive?

Our findings

The provider gave people information on how to make a complaint. People knew how to raise concerns but were not confident action would be taken to resolve them. One person told us, "I've complained to the office so many times about the staff arriving late but nothing is done about it. I've never had a written response to my complaints and now it's as if they are ignoring me." Relatives told us, "When I've made complaints the carers blame the office and the office blame the carers. They are very defensive" and "They have listened to some of our concerns and tried to do something about them but there's still things we're not happy with particularly the carers not turning up on time and they've done nothing to address that."

During our visit we looked at the systems in place to record, respond to and monitor complaints. We looked at a folder which contained written complaints received from people and the provider's response. However, there was not a system in place to record, respond to and log the outcome of complaints made over the telephone. This was the method three of the people we spoke to told us they used to make a complaint. The registered manager and office manager could not provide any evidence that complaints made by people over the telephone were recorded, acknowledged, investigated and appropriately responded to. This meant the provider did not have an effective system in place which enabled complaints to be monitored, used to learn from and drive improvement in the quality of the service.

The provider's failure to establish effective systems to handle complaints amounts to a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff assessed people's needs prior to commencement of care to ensure they could be met. Where applicable a copy of people's assessments received from the local authority were included in their care records. Staff used this information to develop people's care plans. It was evident from the care plans we looked at that people and where appropriate their relatives were involved in the care planning process. This was also confirmed by people we spoke with who told us, "When I first contacted the agency, someone came to find out what help I needed and what I wanted done and that's what they come in and do" and "We discussed what I need and if I want anything different I let them know."

People's support plans were current and contained information about their background and preferences for how support should be provided to them. There was guidance and prompts for staff on how people should be supported in line with their preferred routines, for example, when getting washed and dressed. This helped staff to provide personalised support which focused on meeting people's needs. The provider reviewed people's care plans regularly to help ensure they accurately reflected people's current needs.

The provider sought people's views through telephone calls and visits to people's homes carried out by the care coordinators. People were asked for their views on staff punctuality, personal appearance, attitude and skills. The feedback revealed that punctuality was an issue. The care co-ordinator told us that issues raised by people were raised immediately with staff. However, as mentioned elsewhere in this report, the provider did not have a system in place to ensure that staff punctuality improved.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, we found that although the provider had systems in place to assess and monitor the quality of care people received they were not always effective.

During this inspection, records indicated the provider had systems in place to regularly assess and monitor the quality of care people received. The purpose of providers having such systems in place is to identify areas of the service which require improvement and drive improvement in the quality and safety of the services provided. The systems in place included obtaining people's feedback, audits of people's daily care records and medicine administration records and conducting unannounced spot checks to observe staff delivering care to people.

However the systems in place were not as effective as they needed to be as they had not identified some of the areas which we identified during our inspection. Furthermore, where the provider was aware that an area of the service required improvement they did not always take action to improve the service. For example, the provider's system to assess and monitor the quality of care provided did not identify that people's complaints were not being handled appropriately or that staff were not fully completing records to confirm that people's medicines had been administered. Also, the provider had been aware for at least ten months that there was an issue with staff arriving late to support people but had not taken any action to remedy this. The provider's failure to address these issues impacted people's health and welfare.

The provider's failure to establish and operate effective systems to assess and monitor the quality care people is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17.

The registered manager was not fully aware they had a legal obligation to notify the CQC without delay about certain incidents which had adversely affected the health, safety and well-being of people using the service. The registered manager told us that she did not think she needed to advise the CQC of allegations of abuse because the relevant local authority did so. Records we looked at indicated safeguarding allegations of abuse had been raised about the service since the last inspection. The provider did not notify the CQC about the allegations of abuse at the time they were made and has not done so since we made them aware of their obligation to do so. This meant the CQC did not have oversight of and could not fully monitor any risks associated with the service.

This failure represents a breach of Care Quality Commission (Registration) Regulations 18 (Notifications of other incidents) 2009.

Staff morale was low. Staff felt able to express their views on the management of the service and the way care was provided during supervision and staff meetings. However, some staff felt the management did always take their complaints seriously. Staff told us, "We speak up at the staff meetings but nothing changes so there's no point", "I don't think they care about us. They can be very rude" and "If there is something I'm not happy with I tell them and I do think they try to sort it out but it's also dependent on us [the staff]. The

minutes of a staff meeting held in July 2017 demonstrated that there was a high level of complaints from staff. However, the provider had not taken any steps to address their complaints. We will check whether staff morale has improved when we next inspect the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Care Quality Commission of any abuse or allegation of abuse in relation to a service user.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not establish or operate an effective system for identifying, receiving, recording, handling and responding to complaints by service users and other persons. Not all complaints received were investigated, and proportionate action was not always taken in response to any failure identified by the complaint or investigation,

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not establish or operate effective systems and processes to protect service users from abuse and improper treatment.

The enforcement action we took:

We served the provider a warning notice and told them to meet the regulations by

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager did not establish or operate effective systems or processes to assess, monitor and improve the quality and safety of the services provided.

The enforcement action we took:

We served the provider a warning notice and told them to meet the regulations by