Opika (Care) Ltd

Opika Care Ltd

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 31 March and 1 April 2015 and rated the service as overall good with requires improvement in well-led.

In July 2016 the Commission was made aware that serious allegations had been made about the way in which Opika Care Ltd was being managed and that these matters were being investigated by the police. This investigation is on-going and we will continue to liaise with the provider and police on this matter until an outcome is reached.

The Commission carried out a focused inspection on 17 and 23 August 2016, this inspection sought to consider how effective the day to day management of the service was in light of the allegations made and whether people were receiving safe care and support. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Opika Care on our website at www.cqc.org.uk

This service is registered to provide personal care to people living in their own homes. At the time of this inspection the service was supporting 13 people.

There was not a registered manager in post. 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.

The Commission was not satisfied that the operational and managerial arrangements in place were sufficient to ensure that people received safe and consistent care. We found that despite restrictions being placed on the managerial role of the provider, they remained central to the day to day provision of care and we considered that this was having a direct impact on the protection of people using this service.

There was a lack of supportive managerial arrangements in place; staffing arrangements were chaotic and disorganised. Although people were receiving care and support; there was no planned rota for the staff to follow and people did not know in advance who would be supporting them.

Record systems were fragmented and could not be relied upon. It was difficult to gain a clear picture of the care and support that people needed or of the associated costs. Care plans were unreliable and staff were being verbally instructed by the provider in all aspects of the care and support that people needed.

The culture was closed and inward looking; issues raised were not dealt with in an open or transparent way and this was exposing people to unnecessary risk. The provider had failed to inform the Commission of significant and notifiable events and had failed to implement safe and effective management of the service. This coupled with the restrictions placed on the provider's managerial role meant that people using this

service were being exposed to on-going risk and as such the Commission has taken action to protect them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Inadequate

The service was not well-led.

The provider was restricted in managing critical day to day functions and this impacted on their ability to effectively manage the service and there was no registered manager in post.

The provider had not notified the commission of a police investigation, restrictions on their managerial role within the service or of managerial arrangements made as a consequence of the police investigations.

The provider has failed to notify the Commission of other notifiable issues including the death of people using the service.

Staffing arrangements were chaotic and staff were not receiving the support, guidance and direction they needed.

Record keeping was fragmented and unreliable and all information and knowledge about the service was known by the provider only, was not in writing and was communicated verbally and from memory.

Opika Care Ltd

Detailed findings

Background to this inspection

We undertook an unannounced focussed inspection of Opika Care on 17 and 23 August 2016. This inspection was completed in response to concerns from a police investigation. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics

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 completed by two inspectors and an inspection manager. Before the inspection we reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of some people using the service and the police.

During our inspection we spoke with six members of care staff and the provider.

We looked at documentation relating to the day to day management of the service and staff files.

We were unable to speak to people who used the service because of the on-going police investigation.

Inadequate

Is the service well-led?

Our findings

Prior to this inspection the Commission was made aware that serious allegations had been made about the management of Opika Care Ltd and that there may be on-going risk to the safety of people receiving care and support from this agency. These allegations are subject to an on-going police investigation and whilst the investigation is underway restrictions had been imposed by the police in relation to the provider's role in managing this service.

It is a serious concern that the provider failed to inform the Commission about these allegations, the on-going police investigation into these matters, the restrictions placed on their managerial role or the managerial arrangements put in place to ensure that people were kept safe during the police investigation. During this inspection the provider was unable to offer a reason as to why they had failed to notify the Commission of these matters.

There has been no registered manager in post since November 2015 and the service was operated and managed on a day to day basis by the provider. The Commission was concerned that the restrictions placed upon the provider had a direct impact on their ability to safely manage the service. At the time of our inspection on 17 & 23 August 2016 we were not satisfied that the operational and managerial arrangements in place ensured that Opika Care Ltd was operating in line with legal expectations and providing adequate protection to people using the service.

During our inspection we found that there were no additional managerial support arrangements in place and the provider remained in full day to day control of the service. It was evident that they had a central role in organising the provision of care and support along with the wider management of the service such as invoicing people or their families for the care and support they received. However the managerial systems were chaotic and disorganised, record keeping was extremely poor and failed to provide the information needed to enable a clear picture of the service being provided.

It was difficult to establish how many people were receiving care and support, the nature of their individual care packages, the number of hours of care or support needed and their specific care requirements. The records maintained were not accurate in this regard and we found that all information and knowledge relating to the service was only known by the provider; was all recalled by memory and communicated verbally. The provider was not able / willing to provide a consistent or clear account of each person. We were informed that everyone had flexible contracts and people could increase their support hours on a daily basis. The provider did not have people's care delivery times written down and there was a lack of specific care agreements; therefore it was impossible to determine what care people should be receiving and at what financial cost.

Although summary care plans were in place for each person, these documents were not accurate and could not be relied upon. During our inspection it was evident that staff were being directed verbally by the provider and were not referring to care plans to guide them in the provision of care and support. We saw the provider continually ringing or texting staff and giving detailed directions as to the provision of care i.e. don't

forget to put cream on [person] back; they were also giving staff directions about the administration of a person's medicines. Staff themselves told us that there was very little direction available to them and that they were reliant on the verbal instructions from the provider or updates from each other.

Staffing arrangements were chaotic and disorganised and people using this service did not know which staff member was going to support them on a daily basis. All staff had zero hour contracts and told us that they did not work set hours or have set patterns of work. There was no scheduled shift pattern and staff did not know what they were doing from one day to the next. Staff said that they were notified by text or phone who they would be delivering care and support to and when. They did not like this way of working; but they were used to it. The availability of staff was confusing and they told us that they were texted and told to work even on days when they had told the provider that they were unavailable. This had led to shift swapping and times of care delivery being changed however it was impossible to evaluate how often this happened and the impact it had on people using the service because there were no records to view.

We asked to see staff rotas so that we could assure ourselves about the staffing arrangements in place however there were none available and the provider simply stated that they had it covered. We saw that the provider was on the phone to staff directing who was to cover care and support calls on the afternoon and evening of our inspection. In addition we saw that there were no firm plans for staffing cover for the following day /days.

The provider had a vision that they would care for everyone and 'spoil them' and we saw cards from some relatives thanking the provider for the support offered to their relatives. However we had received a number of concerns from people who have used this service, relatives and staff raising issues about the level of control exerted by the provider. These included putting pressure on people to increase care packages and concerns regarding the financial arrangements in place. Some of these matters remain subject to police and or safeguarding investigations.

We found that the culture in the service was closed and inward looking, the provider had not made the necessary notifications to the Commission and where complaints had been made to the provider there was no evidence that investigations had been undertaken. It appeared that in most cases the provider terminated the care agreement or staff left and found alternative employment.

As a result of this inspection the Commission took enforcement action to ensure that the safety of people using this service was maintained whilst the police and safeguarding investigations are concluded. This was because we were not confident that people would receive safe care and support during this time.