Quality Care Solutions Limited

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Inspection report

Phoenix House
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Harrow
Middlesex
HA1 2SP

Tel: 02038652536

Date of inspection visit:
11 September 2020

Date of publication:
15 December 2020

Ratings

Overall rating for this service	Insufficient evidence to rate

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Quality Care Solutions is registered to provide personal care to people in their own homes. At the time of our inspection the service was supporting one person with personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The person receiving care was at risk of harm because there were no detailed care plans and risk assessments in place. Although this was mitigated by care workers having knowledge of the person's needs and the person's relative confirming needs were met, this remained a concern for us.

Recruitment procedures were designed to ensure staff were suitable for the work they would be undertaking. There were sufficient numbers of suitable staff to provide safe care and treatment to the person receiving care. However, there were no realistic and workable plans for managing staffing levels if the COVID -19 pandemic led to shortfalls and emergencies. We signposted the provider to resources to develop their approach.

We judged the service did not have effective quality assurance procedures to ensure the manager had a clear overview of service performance. There was a lack of formal mechanisms to monitor care. Although we found no evidence that people had been harmed, systems were either not in place or robust enough to demonstrate safety was effectively managed. This gave rise to our concerns, particularly if there were to be an increase in the numbers of people receiving care. However, our concerns were reduced due to the decision made by the service to temporarily cease providing care to new people until improvements were made.

Rating at last inspection
The service was unrated at the last inspection because of insufficient evidence (published 11 December 2018).

Why we inspected
We had concerns in relation to how the service was managed. The service was unresponsive to our queries. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Therefore, ratings will only be assigned to key questions of safe and well-led only. Furthermore, the overall rating will remain unrated because do not have sufficient evidence to do so.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment and governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit this service at a later date to check compliance.

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

The service was not always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Quality Care Solutions 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.

Our focused inspection of Quality Care Solutions took place on 11 September 2020.

Inspection team
The inspection team comprised of one inspector.

Service and service type:
This service is a domiciliary care agency. It provides support to adults living in their own homes in the community. At the time of inspection one person was using the service.

The service did not have a manager registered with the Care Quality Commission.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because it is a domiciliary care agency and we needed to be sure that the registered manager would be in the office.

What we did before the inspection:
We reviewed information we held about the service, for example, statutory notifications. A notification is information about events which the provider is required to tell us about by law.

During the inspection:

We spoke with the manager and the operations manager. We contacted the relative of the person receiving care. We also made contact by phone with two care workers. We examined records of one person using the service. We also looked at personnel records of two care workers, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including staffing rotas and quality assurance processes, to see how the service was run.

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

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was not rated because of insufficient evidence. At this inspection this key question has now been rated as Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• The person receiving care was at risk of harm because the service did not have individual risk assessments. Although care workers were knowledgeable of the risks to the person receiving care, this was not referenced in the "care and support plan", which outlined the individual's needs. For example, although staff were aware of nutritional risk, there was no guidance for them on how to manage and minimise the risks identified. This meant, at the time of the inspection the care records of the person did not contain relevant health or specific information as to the risks and method of mitigating them.
• The person receiving care was at risk of receiving inconsistent care. It was not evident within the "care and support plan" or elsewhere that the person's needs and abilities around personal care and nutrition had been considered. Should this had been documented, it may have assisted in identifying risks, and therefore the level of support the person needed in carrying out those tasks. Therefore, there was a risk of inconsistent care being delivered because there was no support plan or risk assessment to offer guidance and clarity to staff.
• This was an area of concern, which was discussed with the manager. The manager told us there was a detailed support plan kept at the person's home. However, this was not provided to us. We also saw a new IT system had been purchased to enable electronic records to be used, which would allow for effective care planning.
Using medicines safely
• A relative of the person receiving care confirmed their loved one received their medicines, as prescribed.
• The service did not have a MAR (medicines administration record) to record when medicines were given. The manager explained when medicines were administered, this was signed for by care workers in the person's file, which was kept at the person's home. This was inconsistent with good practice, of having a MAR which records which medicines are prescribed, when they must be given, the dose, date and any other special information. Therefore, we could not be assured medicines were being properly and safely managed as prescribed.
• Informal checks of medicines were completed. However, no records were kept. The purpose of an audit is to ensure medicines management and other relevant documentation is in line with how policy states they should operate. Therefore, the audit process did not include a system to ensure such checks were completed, which meant safety issues may have been left unnoticed.

Preventing and controlling infection
• The service had enough supplies of the right PPE. The manager told us staff had received guidance in relation to donning and doffing (put on and take off) standards.

• There were relevant standards and guidance relating to the delivery of care during the pandemic, however, the service was still making improvements as identified from our monitoring activities prior to the inspection.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. The above is evidence of a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• Accidents and incidents were monitored. There was a system for managing accidents and incidents to reduce the risk of them reoccurring. However, during the inspection we saw no evidence of any recorded incidents. The manager explained that no incidents had occurred. Staff understood their duty to raise concerns and report incidents and near misses.
• That said, we were concerned about the time taken by the service to implement any changes following our monitoring activities. On 27 July 2020, we signposted the service to other resources following our assessment that the service required further support to manage the impact of COVID-19 pandemic. However, at this inspection improvements had not been progressed sufficiently.

Staffing and recruitment
• Safe recruitment procedures were in place. This included, proof of identity and Disclosure and Barring Service checks (DBS). However, some records were not available for us to view. These were later sent to us and were appropriate.
• There were sufficient numbers of suitable staff to provide safe care and treatment to the person receiving care. However, there were no realistic and workable plans for managing staffing levels if COVID -19 pandemic led to shortfalls and emergencies. We signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of harm and abuse. A safeguarding policy was in place. Care workers had received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. They were aware they could notify the local authority, the Care Quality Commission and the police when needed. Where safeguarding concerns had been identified, the manager had taken appropriate action.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was not rated because of insufficient evidence. At this inspection this key question has now been rated as Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• There was an informal culture, characterised by absence of formal systems and processes. We found this to be related to the size of the service. Quality Care Solutions is a small service managed by one director, who is supported by an operational manager, service manager and two care workers. The manager explained to us that in as much as they had informal structures at the present time, it was not time-consuming for them to cascade information within the organisation. As such, they told us all staff were fully informed of their roles and responsibilities. This was confirmed by care workers. They told us they were supported to do their work, citing frequent informal interactions with the managers.

• The absence of formal mechanisms to track and monitor care was a concern, which we discussed with the manager, during and post inspection. We found no evidence of monitoring systems such as audits and satisfaction surveys. Whilst from our conversations with relatives, and speaking with staff, we found no evidence of any negative impact on the care being delivered, assurances could not be made that this was sustainable in the long run, particularly if there was an increase in the numbers of people receiving care.

• Whilst there were concerns raised during this inspection, we were provided with assurances by the manager. Following the inspection, they wrote to us stating they were taking our concerns on board and therefore had placed a voluntary embargo not to admit any new people until they had met the required improvements. Additionally, the service was implementing a new IT system. It was explained to us the new system would facilitate care planning and quality monitoring. Should this be successfully implemented, we judged the service would benefit from formalising organisational processes as this would facilitate coordination and provide clarity for quality management.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• The culture at the service did not support high quality sustainable person-centred care. We could not evidence effective care planning to ensure people received high quality individualised care. However, the relative of the person receiving care confirmed the person received individualised care. Whilst it may have been possible to deliver care to one person without formal structures, there remained a risk of inconsistent care. Our view was that regardless of the number of people receiving care, improvements were required to ensure there were standards and systems to adhere to all the time.

• There were inadequate mechanisms of empowering staff. Staff files viewed showed formal staff meetings,

supervision and appraisals had not been carried out. Whilst care workers felt supported, it is good practice for staff to sign and confirm when they have read and understood information. Our view was that the organisation was not structured properly, with clear processes and procedures to empower staff to enable them to independently know where to turn to in dealing with matters related to their day to day activities.
• Apart from procedures and processes, the organisation's mission and values were not documented. Feedback from the managers showed they had a vision and a set of values in their minds, but these were not documented. It is good practice to document the organisation's mission and values as this help to guide and direct staff behaviours. Therefore, assurances could not be made that staff shared the organisation's vision, values and had contributed to them.

Continuous learning and improving care, working in partnership with others
• There was limited evidence of learning and improvement. We spoke with the provider about this and from their description, learning was informal and not documented.
• Even though there was evidence of interacting with other organisations, including the CQC and local authority, there was no evidence any learning had been transferred to the organisation. For example, although support had not been required from the local services, the service was not fully aware of the local resources available to them.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety and quality monitoring were effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• The provider was aware of her legal duties in relation to duty of candour. This is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm because the provider did not assess and document risks to their health and safety.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were at risk of harm because the provider did not have systems and processes that enabled them to identify and assess risks to the health, safety and/or welfare of people who used the service.