Daily Care 4 U (Telford) Ltd

Glebe Centre

Inspection report

The Glebe Centre
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection relates only to Daily Care 4 U (Telford) Ltd and does not in any way relate to other business/charities/providers who may be operating out of The Glebe Centre.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults. At this inspection they were providing personal care for 49 people.

Daily Care 4 U had a registered manager in post who was present throughout this inspection. The registered manager was also the registered provider. 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.

We carried out an announced comprehensive inspection of this service on 13 June 2018. Breaches of legal requirements were found. These included, failure to protect people from abuse, failure to ensure fit and proper persons were employed, failure to ensure safe care and treatment, failure to deploy suitably qualified, competent and experienced staff, failure to provide person centred care, failure to act on complaints, failure to make appropriate notifications and failure to have systems and processes in place that ensure that they assessed, monitored and drove improvement in the quality and safety of the services provided. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Glebe Centre on our website at www.cqc.org.uk

At this inspection we focused on the key questions 'Safe' and 'well-led'. We found the provider was still in breach of regulations regarding the safe treatment of people, protecting people from harm and abuse, fit and proper persons employed and ineffective quality assurance systems. In addition, we found them to be in breach of their duty of candour. This means that they were not open and honest with people when things had gone wrong.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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.

People were not safe from the risks of ill-treatment and abuse as the provider failed to recognise and respond to allegations which could potentially harm people. The provider failed to follow safe recruitment practices when employing staff members and failed to complete robust risk assessments regarding staff members. People were at risk of harm when receiving assistance with their medicines as the provider did not have the systems to assess whether or not people received their medicines as prescribed. People were at risk of harm in relation to their care and support needs as there was insufficient assessment or guidance provided to staff on how to safely support someone with their identified risks. The provider had not embedded effective infection prevention and control practices. People were at risk of missed calls as the provider had insufficient systems in place to monitor staff member's attendance.

The provider failed to keep themselves up to date with current practices in health and social care. There were insufficient quality monitoring checks completed to identify or respond to poor care practices. The provider did not act in an open and transparent manner when things went wrong. The provider did not safely secure people's personal information. Policies and procedures were in place but these were not followed. The provider did not follow their own policies and procedures when unsafe and abusive staff practice was raised with them. The provider failed to make the required notifications regarding significant events occurring in their service.

You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not protected from the risks of harm or abuse. The provider did not have systems in place to recognise, report or respond to allegations made to them. The provider did not complete individual assessments of risk associated with people's care and support. People did not receive their medicines safely and the provider failed to keep accurate records of people's medicines. The provider failed to record or investigate incident, accidents or near misses. The provider had not embedded effective infection prevention and control assessments or procedures.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's governance was ineffective to assess, monitor or drive improvements to ensure people received a safe and effective service. The provider did not keep sensitive and private information securely. The provider failed to act when there were breaches in data security. The provider failed to make necessary notifications regarding significant events. The provider failed to keep themselves up to date with best practice in adult social care.

Glebe Centre

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 checked 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 relates only to Daily Care 4 U (Telford) Ltd and does not in any way relate to other business/charities/providers who may be operating out of The Glebe Centre.

We undertook an announced focused inspection of Daily Care 4 U (Telford) Ltd – Glebe Centre on 11 July 2018 and this was completed by two inspectors. One inspector visited the office location to see the registered manager and to review care records and policies and procedures. Following this a second inspector spoke with staff members on the telephone.

This inspection was completed to check that improvements to meet legal requirements planned by the provider after our 13 June 2018 inspection had been made. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This was because the service was not meeting some legal requirements.

Significant improvement was also needed in the remaining Key Questions at our last inspection. However, the provider was still working to make the changes required to make them compliant with the regulations and these were not inspected at this inspection. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

Before our inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law.

We asked the local authority and Healthwatch for any information they had which would aid our inspection. We used this information as part of our planning. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

We spoke with the registered manager and three staff members. We reviewed the care and support plans for four people including the assessment of risks and medicine administration records, any records relating to incidents or accidents and quality assurance records.

Inadequate

Is the service safe?

Our findings

At the time of our last inspection completed in June 2018 the 'Safe' key question was rated as 'inadequate.' At this inspection we continued to have serious concerns about the safety of the service and we identified continued breaches of legal requirements and have rated this key question as 'Inadequate.'

At our previous inspection we found that people were not protected from the risk of abuse as allegations of abuse had not been reported or investigated. At this inspection we found that the provider still did not have effective or consistent systems in place to recognise, report or respond to safeguarding issues. For example, we found continued concerns regarding one person's care and support plans which necessitated us making a safeguarding referral to the local authority to assure ourselves that this person was safe and their needs were being met. The provider had failed to recognise that the lack of accurate assessments of people's care and support needs put them at the risk of harm or injury. The provider did not have the systems, practices or managerial oversight in place to keep people safe from abuse in the form of neglectful care.

This was an ongoing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we had found that the provider did not safely manage people's medicines. At this inspection we looked at people's medicine administration records (MAR). We attempted to look at the most recent records but the provider could not locate these for us to look at. Those that the provider could locate related to care and treatment since our last inspection. These contained omissions in them and did not contain the information staff members would need to safely support people. For example, one person was in receipt of an anticoagulant. This is a medicine that stops blood clotting. There was no information for staff members regarding what the medicines current dose was or any side effects. We identified missed doses when we looked at the person's MAR. We asked the provider about the missed doses of medicines regarding this person. They explained that the person was in hospital at the time so the staff would not be supporting them. However, when we looked at the daily recordings for this person it was evident that staff members were supporting them throughout this period with no evidence of admissions to hospital. After talking further with the provider, they confirmed that they were not aware of these omissions as they had not checked the relevant records. At our last inspection we raised concerns with the provider that they were not checking the recording of medicines. These latest omissions mean that the provider is not learning from past experience. The provider still did not have systems in place to recognise and accurately respond to concerns regarding the administration and recording of people's medicines.

We attempted to look at the records of one person who was in receipt of a controlled drug. This is where a medicine's manufacture, possession, or use is regulated by government. However, we were not able to do so as the provider could not locate the relevant MAR sheets. There was no risk assessment or records of balance or handover in relation to the administration of this drug. This put the person at risk of not receiving their medicines as prescribed and the drug being misused as the necessary checks and safeguards were not in place. The provider did not have a system in place to effectively monitor the use of this drug or to identify any concerns regarding its safe use.

We found that the provider could not assure us that people's records were accurate, complete, legible, up-to-date or securely stored. When we followed up our concerns with the provider regarding the missing MAR they told us, "They may be at home. I have a large bag where a lot of these things go." People were at risk of their personal and confidential records and information being lost or misused as the provider's systems did not secure their information safely. This meant that people could not be effectively kept safe as records relating to their care and support were either mislaid or missing preventing staff members from accessing and referring to them.

At our previous inspection we found the provider did not have systems in place to identify, record or respond to accidents, incidents or near misses. At this inspection we found there had been no improvements. For example, following one staff member's arrival at a person's home they had cause to call the emergency services and the person was admitted to hospital. Although the staff member responded to a situation and sought assistance from professionals this was not effectively recorded by the provider. The provider was not able to tell us about the circumstances of the hospital admission. The lack of effective systems in place to record and monitor significant events put people at risk of repeated incidents as these were not analysed to identify any patterns or whether or not additional action was required.

Previously we found that people did not have comprehensive and up to date assessments of risk associated with their personal care and support. At this inspection we found that this was still a concern. For example, we identified one person was at risk of skin breakdown. They were also diabetic and had additional health conditions which would increase their risk of poor skin integrity. The provider did not have assessments in place to plan and support this person to meet their needs regarding these known risks. We asked the provider about the lack of diabetic care and support plan. They told us, "I have never done a diabetic care plan. Why would I?" As we could not be assured by the provider that this person was receiving care and support that met their needs we passed our concerns to the Local Authority for them to investigate.

People still did not have accurate or personal assessments of risk based on the environment within which they lived and where they were supported. For example, we looked at one person's environmental risk assessment. The fire evacuation plan stated that they should be taken through the front door or through the back door. We went through this assessment with the provider. This assessment was the same identical assessment as another person receiving support from Daily Care 4 U. However, one person lived in a house and the other lived upstairs in a flat complex. The provider told us a member of staff, who was no longer employed by them, had completed these assessments. However, we confirmed with the provider that they did not read the assessments to assure themselves that they were accurate and based on the individual circumstances of the person receiving support. This put people at risk or injury as the information for staff members, in the event of an emergency, was inaccurate and misleading.

At our previous inspection we found that staff did not consistently follow infection control procedures to prevent the spread of infection. At this inspection we found that infection prevention and control practices were still not embedded by the provider. This put people at risk of contracting avoidable illnesses. For example, we looked at the individual assessments for people and how staff assisted and prepared their meals. All of the assessments we looked at stated the same thing that, "There was not a cutting board," in the person's home. We asked the provider about this and they confirmed that they did not read through these assessments to ensure that they were accurate and personal to the individual receiving care and support. The assessments we looked at were generic and did not contain the relevant information for staff members to safely support people. For example, all the assessments we saw indicated that a "spray cleaner" was located under the sink. We saw this statement in all the assessments we looked at. Again, we asked the provider about this and they confirmed that they did not read these assessments and that they were generic. Despite the lack of individual assessment and risk assessments staff members we spoke with told

us that they were provided with the necessary equipment to do their role. One staff member said, "(Daily care 4 U) gives staff all the aprons, gloves and hand gels that they need to do the work."

The provider still did not have systems or processes in place to analysis incidents to identify any lessons learned or identify any themes. As a result, they failed to take corrective action which put people at continued risk or receiving unsafe care and support. For example, the provider failed to check medicine records despite these concerns being previously identified to them in our published report following our inspection in June 2018.

These issues were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the provider did not follow safe staff recruitment practice. For example, at our last inspection we identified two staff members who had negative information identified on their Disclosing and Barring check (DBS). The (DBS) helps employers make safer recruitment decisions and prevents unsuitable people from working with others. Following our last inspection, we required the provider to complete a risk assessment regarding these staff members. The risk assessments we received were confused and incomplete. One assessment referred to negative information which had not been recorded on the DBS check and both had sections regarding who was at risk and the nature of risk missing. People were still at risk of being supported by staff members unsuitable to the role as the provider did not complete robust assessments on known risks.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider still did not have effective scheduling systems in place to assure people that staff members would arrive on time. For example, on the day of this inspection we identified that the provider had not allocated 28 calls to staff members for that day. We had to briefly stop our inspection for the provider to rota staff members to ensure people received their care and support. We looked at the staff allocation schedules for the four weeks prior to this inspection. There were significant gaps where people did not have a named staff member supporting them on a call. We saw that some staff members were allocated care calls at the same time where they were expected to be elsewhere. The provider told us this was an error and someone else should be doing the calls but they had not allocated it.

We raised these concerns with the Local Authority who contacted several people receiving support from Daily Care 4 U. They indicated that they had not had any missed calls. However, the provider's systems put people at risk of not receiving the care and support agreed to meet their needs. Staff members we spoke with provided differing opinions regarding the rota's and timeliness of calls. One staff member said, "The rota is given out in enough time if everyone did what they should." They went on to say, "We have had incidents of staff dropping shifts in the middle of the day and other carers have to pick this up, this makes getting all the calls in hard work but we do our best."

Inadequate

Is the service well-led?

Our findings

At the time of our last inspection completed in June 2018 the 'Well-led' key question was rated as 'inadequate.' At this inspection we continued to have serious concerns about the management and the governance of the service and we identified continued breaches of legal requirements, and one additional breach of legal requirement, and have rated this key question as 'Inadequate.'

Following our previous inspection, we took urgent enforcement action asking the provider to improve the quality of the service and to ensure people were receiving safe and effective care. We carried out this inspection to look for improvements and found no improvements had been made and that people were still at risk of receiving unsafe care.

At our previous inspection we found that the provider did not have effective quality monitoring systems in place to ensure people were receiving a good service from them. At this inspection we found that there were no improvements in this area. For example, the provider told us, as part of their risk assessments of staff, they would undertake spot checks to ensure they were working as expected. We asked to see copies of these spot checks. However, the provider told us they were not yet doing them. This meant that the provider could not assure themselves, or us, that staff members were working to the standards expected of them.

We asked the provider what changes they had made since their last inspection. They told us they had changed how they recruited people and also updated people's care and support plans. We asked which care and support plans had been updated but they could only identify one person with an updated record. When we looked at this record we saw significant omissions to their plan of care. This included a lack of environmental risk assessment, moving and handling assessment, diabetic care plan, medication care plan and risk assessment.

We asked the provider if they were following a recognised system of care planning and they told us that they were not following a specific system. We enquired how they were prioritising people in terms of risk and need. They responded that they had a plan in place. We enquired further but they could not tell us what this plan was. The provider did not have effective systems for identifying improvements and making changes necessary to afford people 'Good' care and support.

The provider still did not make effective use of their information technology systems in order to improve the care and support experiences for people. For example, we asked the provider how many hours of care they provided and how many hours of staffing they had available. This information was not available to access. We requested details of people and the amount of support they received but this could not be provided. We made attempts to contact staff members by phone to talk with them about their experiences since being employed by Daily Care 4 U. Unfortunately, several of the contact details provided to us were incorrect and we could not contact key members of the care and support team. People were at risk of receiving poor quality care as the providers information technology systems were not effectively used.

At our previous inspection we found the provider failed to follow their policies and procedures for

addressing unsafe staff behaviour. At this inspection we found that this was still an area of concern. For example, the provider failed to complete checks regarding the administration of medicines. As a result, they failed to act on concerns or assure themselves, or us, that people had received their medicines as prescribed to maintain their well-being.

We asked the provider how they kept themselves up to date with best practice and what support and assistance they had since our last inspection. They highlighted that they had spoken with a different company regarding their policies and human resource advice. The provider told us that the work regarding policies and procedures may take some time and the arrangements with this external company had yet to be finalised. The provider further told us that they were members of a local provider representative association and that they were considering contacting them for advice and support albeit they had yet to seek this support. People were at risk as the provider was not keeping themselves up to date with best practice in adult social care.

The provider had links with other healthcare professionals and support systems in the local community. This included those responsible for specialist assessment. For example, occupational therapists who undertake assessments to help people to carry out everyday activities which are essential for health and wellbeing. However, owing to inconsistencies in the record keeping and care planning the provider could not accurately identify to us when such referrals had been made and the outcome of any recommendations.

The registered manager was also the registered provider. They did not fully understand the requirements of their registration. They had not appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. For example, at our inspection in June 2018 we identified we had not received appropriate notifications from them regarding significant incidents. We agree they could make these retrospectively to us. At this inspection they still had not made these notifications. We asked why they had not made the notifications that they were required to make. The provider told us it was because no one had sent them the forms. We explored this further with the provider but they were not able to describe the types of notification they needed to submit or the correct process to follow. We asked why they had not sought advice or guidance regarding this but they were unable to clarify this further. This demonstrated a lack of understanding regarding the notification process and their requirements as part of their registration with us.

These issues constitute an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the provider did not have robust arrangements in place to ensure the security, availability and integrity of confidential information. For example, when we asked to look at the records of medicines these could not be located and the provider thought that they may be in a bag at their home address. We asked about missing records and care and support plans. The provider told us that a previous staff member must have deleted them from the computer system. However, the provider had not done anything to retrieve this information, investigate or identify it as a potential data security breach. We asked the provider how they were doing things differently as a result of such breaches in data security. The provider could not identify any learning from these incidents. This put people at risk of having their confidential and personal information misused.

We asked the provider about informing people who may be affected as a result of breaches in data security and missing records. The provider told us that they had not thought that they needed to and had not contacted anyone to inform them. The provider was not acting in a way which was transparent and open

and did not engage people potentially affected by such incidents.

We looked at the values and principles underpinning Daily Care 4 U's services. Daily Care 4 U provided Information to us, and to members of the general public, stating that they were specialists in dementia care. We enquired about this with the provider who told us that they were not specialists and that this was an error. This information was on their newly created website which went on to say that they were compliant with a piece of legislation which was in fact outdated and not related to their registration with the Care Quality Commission. The provider told us that they would look into this as they wanted to present clear and accurate information to people.

Staff members we spoke with told us they found the provider to be supportive and approachable. One staff member said, "[Provider's name] is at the end of the phone 100% of the time." They went on to say that the provider will always step in and support the staff no matter what the situation was.