Denise Quality Care Services Limited

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Inspection report

Thurrock Centre for Business, Unit 1
2 George Street
Grays
Essex
RM17 6LY

Tel: 01375809802

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14 June 2017
15 June 2017
20 June 2017
21 June 2017
28 June 2017
29 June 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Denise Quality Care Services Limited provides personal care and support to people in their own homes.

The inspection was completed on 14, 15, 20, 21, 28 and 29 June 2017. At the time of the inspection there were 12 people who used the service.

A registered manager was in place at the time of the inspection. 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 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

There was a lack of provider and managerial oversight of the service. Effective quality assurance checks were not in place to enable the provider to assess and monitor the service in line with regulatory requirements or to improve the quality and safety of the service. The provider's arrangements were not robust as they had not recognised the issues we identified during our inspection. Improvements were required by the provider to ensure that all staff employed by the service received effective training.

Proper recruitment checks had not been completed on all staff before they commenced working at the service and processes had not been operated in line with the provider's own policy and procedures. Suitable arrangements were not in place to ensure that newly employed staff received suitable training opportunities, robust induction, formal supervision and an annual appraisal of their overall performance.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service. Steps to ensure people's and others' health and safety were not always considered and risk assessments had not been developed for all areas of identified risk.

Although people told us that they were kept safe, staffing levels were not always suitable to meet people's needs. People told us that there had been no missed calls and staff had been punctual with times they were expected at people's homes. People received their medicines at the times they needed them although not all staff had undergone training to carry out this task.

People spoke positively about the way staff treated them and reported that they received appropriate care. Staff demonstrated a good knowledge and understanding of the people they cared for and supported. People told us that their personal care and support was provided in a way which maintained their privacy and dignity. Although we found that people's care plans did not contain relevant and current information to guide staff on the most appropriate care people required to meet their needs.

You can see what actions 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.

Improvements were required to the provider's recruitment procedures so as to safeguard people using the service.

Proper arrangements were not in place to manage and mitigate risks to people's safety.

People received their medicines at the times they needed them although not all staff had undergone training to carry out this task.

People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive effective induction and training to ensure they had the right knowledge and skills to carry out their roles and responsibilities to an appropriate standard or to meet people's needs.

Staff were not effectively supported in their role through regular formal supervision, 'spot visits' and appraisal of their overall performance.

People's nutritional and healthcare needs were identified to ensure that they received proper support from staff.

Is the service caring?

Requires Improvement

The service was not always caring.

Although people told us that they were treated with kindness and consideration by staff and staff demonstrated a good knowledge and understanding of the people they cared for and supported, the provider did not provide a caring service as they had failed to ensure people's safety and wellbeing at all times. The had not ensured people's care needs were being met in all

areas of required practice inline with regulation.

Care records for people did not contain information on people's preferences and choices fully or clear instructions on how staff would meet people's needs.

People told us that they were treated with respect and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's support plans did not reflect information to guide staff on the most appropriate care and support people required to meet their needs.

People's needs were not assessed, reviewed and recorded appropriately.

People's views and preferences had not been included when support plans and care records were devised.

Is the service well-led?

Inadequate

This service was not well-led.

We found that the provider had failed to implement a robust quality monitoring system that operated effectively to ensure compliance with regulatory requirements.

The provider had failed to recognise and identify the shortcomings in the service so as to improve the quality and safety of the services provided.

Denise Quality Care Services 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 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 took place on 14, 15, 20, 21, 28 and 29 June 2017. One inspector undertook the inspection although on the date of 15 June two inspectors were in attendance. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available.

Before the inspection we reviewed the information we held about the service; this included incidents they had notified us about. We also contacted a local authority safeguarding team to obtain their views. A Provider Information Return (PIR) had not been requested from the provider on this occasion. The PIR 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 made telephone calls to people using the service, their relatives and staff and we also visited people in their own homes. We spoke with six people or their relatives and four staff members. We also spoke with the provider and registered manager. We reviewed care records and medication records for five people who used the service.

We saw records about how the service was managed. This included six staff recruitment and monitoring records, staff schedules, provider's policies, procedures and records that related to the management of the service.

Inadequate

Is the service safe?

Our findings

Appropriate arrangements were not always in place to manage risks to people's safety. Where assessments were in place we found that these solely related to people's home environment. Other risks relating to people's health and wellbeing had not been considered. For example, two people required catheter care. There was no support plan in place detailing the specific care and support to be provided or if the person was able to self-manage their catheter. No risk assessments were evident for those people who required catheter care and the associated risks, such as, catheter blockage and pain and discomfort to the person. Furthermore, risk assessments were not always fully completed for people's movement and handling needs. For example, one person was assessed to require the use of a wheelchair, there was no clear instruction on how the person required assistance to transfer from the wheelchair when required. Another example was, no risks assessments had been completed for a person who required an invasive procedure as part of their support to meet their care needs. Staff had also not received any structured and formal training by a qualified person on how to complete the procedure safely. This meant staff had no clear instruction how to carry out this procedure safely or how to manage any risks associated with this procedure. Although there was no impact to suggest that people's needs were not being met, the above risks had not been identified or anticipated and people were at potential risk of receiving care and support that was unsafe and did not meet their needs.

People told us they received their medication as they should and at the times they needed them. One person told us, "They [care staff] give me my tablets in the box that the pharmacy fill up." Another person told us, "The staff come in and give me what is in the box [dossette] on the side." We looked at the care records for two people who required support with their medication, there was no evidence in both records of a medication risk assessment being completed. Therefore it was not clear on how people required support with their medication.

The provider had a medication document in people's homes; this was for staff to sign when they had given support with medication. We viewed two medication documents, we found that they had not been completed fully, one had not recorded what type of medication was prescribed or how the medication should be taken. The document was recorded as 'Dossette box given'. Another medication document was completed with the details of the prescribed medication and staff had signed to say they had given the medication daily, although a family member with advice from the GP had been giving the medication in the person's food and staff did not always witness the medication being placed in the food. Therefore staff could not be sure what medication was being given or if in fact it was the correct medication. This meant that people could not be assured they were receiving medication in a safe way.

We reviewed staff records and found that the provider had not provided staff with medication training. One member of staff told us that they had received medication training but this was prior to them being employed by Denise Quality Care Services Limited. The provider did not have any further competency checks or regular review of staff practice in place to ensure staff were safely delivering this aspect of people's care.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected but this was mainly within the service. For example one member of staff told us, "I would report any concerns straight to my manager and they would deal with it." Although when we asked about reporting a concern externally from the service, the staff member was not aware of external agencies that they were able to report to. For example, Local Authority, Police or CQC. There was a lack of understanding from the provider and registered manager on the process and procedures of raising a safeguarding concern to external agencies. When we asked the provider how they would inform the Local Authority about a safeguarding concern, they were unaware of the forms or documentation required. We found records indicating that staff were concerned for a person's wellbeing in terms of a relative's interventions. No attempt had been made by staff to discuss this with management and in turn because there had not been appropriate oversight management was not aware of staff's concerns. Although it was clarified during the inspection that there was no risk to the person, it had not been considered at the time and only through the Commission's intervention was the matter reviewed. This showed that systems and process were not established or operating effectively.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not able to show that effective and proper recruitment checks had been completed on all staff before they commenced working at the service. Staff recruitment records showed that the provider's recruitment practices required improvement and had not been operated in line with the provider's own policy and procedure. The provider's recruitment policy and procedure detailed that the provider followed a rigorous recruitment process and this included exploring people's employment history, requesting two written references and receiving an enhanced disclosure from the Disclosure and Barring Service [DBS].

The above did not concur with our findings. We found all of the five staff files we looked at did not contain people's full work history; one only contained the previous two years employment history. There was no evidence that the provider had explored or investigated the gaps in people's work history. Four staff files showed the incorrect amount of references as required. Although we found thatall staff had received a DBS check, there was no clear evidence of each member of staff's start date as there were no contracts held between the service and staff at the time of our inspection. Therefore we could not be assured that staff members were not working prior to receiving the appropriate checks to ensure that they were considered suitable to work with vulnerable people.

During our inspection we visited a person in their own home to gain their views on the service they received from Denise Quality Care Service Limited. The person was happy with the care received and was complimentary about the staff member that provided the care. However we were told verbally by the provider and registered manager the name of the staff member who provided the care prior to the home visit and this staff member's name also showed on the rotas that had been provided by the service. However, whilst visiting the person at their home it became apparent that is was not the same person that should have been providing the care. We asked the 'staff' member their name and they gave a different name to who we expected to be at the property. On further investigation by looking at a list of staff names given to us by the provider, we saw this person's name was not on the list. We called the registered manager immediately who told us that he was not available to come to the home address but would ask the care co-ordinator to meet us there.

The care co-ordinator came to the person's home and told us that the 'staff' member was on training and that they should have been working with them. We met with the provider and registered manager to discuss this matter and found that this person was a 'friend' of the care co-ordinator and that the person was not employed by the service and therefore had not undergone any employment checks to ensure the person was eligible to work. The registered manager and provider told us that they were not aware that this person was providing care or entering the person's home. This showed that robust measures had not been undertaken to ensure that people were safe and being cared for by staff that had undergone robust checks to ensure they are suitable and eligible to work with vulnerable people.

A safeguarding alert was raised and referred to the Local Authority safeguarding team.

These failings are a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were safe and had no concerns about their safety. One person told us, "They [staff members] are good, they do everything I need." Another person told us, "They [staff members] are always reliable and on time." One relative told us, "I feel that [relative] is safe with the staff that visit, they make sure [relative's name] has what she needs."

People told us that there were not always sufficient numbers of staff available to provide their care. People told us they had a consistent team of staff supporting them. People told us that care staff always completed the care tasks required. One person told us, "I know who is coming to me as I have the same person each time." A relative we spoke to said "Things have settled a bit and [relative's name] mostly has the same carer each day."

The registered manager and provider told us that they were actively looking to employ more staff but had found it difficult due to not being able to offer staff the amount of hours they are seeking. The provider said, "People don't want to work for just a few hours here and there so they go to companies that can offer them lots of hours."

Requires Improvement

Is the service effective?

Our findings

People who used the service and their relatives told us in their opinion that staff were suitably trained, skilled and competent to meet their needs. However, although staff told us that they had received some training during their induction, it was apparent from our discussions with staff that the training had not always been effective. Staff's comments about training provided were variable. One member of staff told us, "I had manual handling training on my induction and I shadowed other staff to see what to do before I went out on my own." Another staff member said, "I have had some training here but I have also had training in other jobs."

We asked the provider and registered manager for training records for staff. They were unable to provide a list of what training staff had completed, therefore we looked at staff files to evidence training certificates for each member of staff. We looked at five staff files and found training certificates for each member of staff that showed 'completion of care certificate' with a list of subjects covered. The list included Safeguarding, Moving and Handling, Fire Safety, Communication and Health and Safety. The registered manager told us that this training is provided by an external company and all subjects are covered in two days of induction. We asked the registered manager how staff are assessed following the training to ensure they are competent, the registered manager could not evidence that staff were assessed following the training to ensure they were competent or to see if the training had been effective. The registered manager said that he had carried out 'spot checks' on occasions but did not have documentation to evidence these. Therefore we could not be assured that staff had been provided with training that equipped them with the skills and knowledge to undertake their role and responsibilities, meet their personal training and development needs and to ensure people's needs were being met safely and to an acceptable standard.

Staff confirmed they had not received specific training relating to catheter care or other specific assessed needs people required and that instruction had been given by other members of staff who were not trained to deliver this specific training.

The provider had an induction policy and procedure in place. Some staff we spoke with told us that they do not believe they had completed the induction process fully. We spoke with the registered manager who advised us that staff undergo an induction process but agrees this has not been robust.

We saw from records that staff had not received supervisions, the registered manager told us "It is hoped that supervisions will be held four times a year but none have been done as of yet." One staff member told us, "I feel supported by the company and have no problems." Another member of staff said, "I do feel supported but sometimes you need to call and just be able to speak and be listened to." The registered manager told us that appraisals had not been completed at this time but this would be starting in the near future. This meant formal support measures were not in place for staff. People using the service did not benefit from a well-supported staff team through the provider's arrangements relating to training, supervision and appraisal.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We spoke with the registered manager and provider who told us that there had been no training on the Mental Capacity Act 2005 for staff employed at the service. When speaking with staff none of the staff were able to demonstrate an understanding of the requirements of the Mental Capacity Act 2005 and what this meant for people using the service, however staff understood how to give people choices in their day to day lives. The provider assured us that this training will be delivered and staff updated on the requirements of the Act. At the time of the inspection the service was not providing care to anyone who lacked capacity or did not have an appropriate person such as a family member with power of attorney to speak to their needs.

Where appropriate people had access to health professionals as required. Staff told us that if there were concerns about people's healthcare needs they would initially discuss these with the office staff or family members. The registered manager told us if staff were concerned about a person's health and wellbeing they would relay the concern to the care co-ordinator or them for escalation and action. We saw an example of this in a person's daily notes when staff had contacted the care co-ordinator with regards to a person's health needs.

Where people required support with eating and drinking, people's needs were being met and people were happy with the care staff were providing in terms of their nutritional support needs.

Requires Improvement

Is the service caring?

Our findings

Overall people and those acting on their behalf told us that staff cared for them or their member of family in a caring and compassionate way but our findings in terms of how staff were trained and supported to ensure people's wellbeing and all support functions including support plans and management support did not concur with people's comments about a caring service. Although people told us that they were treated with kindness and consideration by staff and staff demonstrated a good knowledge and understanding of the people they cared for and supported, the provider did not provide a caring service as they had failed to ensure people's safety and wellbeing at all times. The had not ensured people's care needs were being met in all areas of required practice inline with regulation.

Although staff we spoke with appeared to have a good understanding of the people they were caring for, this was due to the relationship they had built with the person. Care records for people did not contain information on people's preferences and choices fully or clear instructions on how staff would meet people's needs.

People's comments about the service included, "I get on with the carers really well and they look after me." Another person told us, "I like them [staff], they are always very nice to me." A relative we spoke with told us, "The staff are good and now we have a regular carer, they know [relative's name] needs to be helped." One person was very complimentary about a staff member and told us, "Nothing is ever too much for [staff member], they will do anything I need and are always caring."

People told us that their personal care and support was provided in a way which maintained their privacy and dignity. They told us that the care and support was provided in the least intrusive way and that they were always treated with courtesy and respect.

Requires Improvement

Is the service responsive?

Our findings

People's support plans did not include information on how people would be supported to meet their assessed needs, although the information did provide the number of staff required to provide support each visit and the length of time for each visit. The provider told us that a pre-assessment of people's needs would be carried out prior to the person's care package commencing with the service, and the information gained during the pre-assessment would be used to devise people's support plans. We could not find any records of the pre-assessments being completed. Records also showed that assessments relating to 'environmental risks' were completed but no further risk assessments had been completed.

Improvements were required to ensure that risks to people's health, wellbeing and safety were identified and recorded. No evidence was available to show that the content of the support plans had been agreed with the person who used the service or those acting on their behalf. The registered manager and provider were advised that information to evidence this process should be included to show people and those acting on their behalf involvement in the assessment process and where appropriate had signed to state that they agreed with the content of the support plan. Therefore we could not be assured that the care and treatment of people was appropriate or met their needs fully in a person centred way.

We viewed five people's records and found information recorded was limited and did not include people's personal history or individual preferences. People's support plans did not give clear information on how to care and meet people's needs. Therefore staff would rely on information passed from other members of staff to inform them on how to support people. We spoke with staff who told us, "[staff member name] told me what was needed to help [person's name]." Another staff member said, "No, there is not any information on what is required for each person but we are told by the manager what is needed." This meant that people's care records were not written in a person centred way and did not reflect their preferences .

People were not given regular opportunity to comment or feedback about their care. They were not being actively involved in their care delivery and regular review of their care.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they had not received any complaints but had systems in place to deal with complaints if they were received. We spoke with people who use the services and they told us that they had not had to formally complain to the service, although one person told us, "I have called the office and spoke with [provider] before but that was for minor things. They listened to me though." The service did act to address the issues that had been reported.

Due to the nature of the care being delivered the service did not actively support people with their social and recreational needs as part of their packages of care.

Inadequate

Is the service well-led?

Our findings

During the inspection we identified a significant lack of robust oversight and leadership within the service. This had led to an inability to demonstrate to the Commission how the service was being run and managed in a safe way. This directly affected the stability, safety and welfare of the people receiving care. We identified that people's personal safety was compromised and exposed them to the risk of harm in a number of areas, for example poor training and recruitment practices. There was a lack of systems in place to ensure shortfalls were being identified and prompt action was being taken to mitigate the risks.

We found systems and processes were not operating effectively to assess and monitor the quality of service that was being provided. The provider was not assessing, monitoring and improving the quality and safety of the service provided. A 'staff member' was working for the service that had not been recruited at all and a person was receiving care for an invasive procedure with staff not adequately trained to deliver this care safely, furthermore staff were signing medication records where covert medication was being given by the family without witnessing the medication being placed in food. These were all examples of failings in the service that had not been picked up by the provider because of their complete lack of oversight. Placing people's safety and wellbeing at risk.

Care plan reviews for people had not been completed on a regular basis. Care records for people had not been completed to include information on how to support people to meet their assessed needs, this meant staff did not have clear and up to date information on how to support people and relied on communication from other staff members. Therefore the provider had not maintained an accurate record including the care and treatment provided to each person who used the service. During the inspection we could not find evidence that staff competencies and observational supervisions had taken place. Therefore the provider was unable to evidence how they were monitoring the different aspects of the service to ensure continued improvement and safe delivery of care.

The registered manager told us that the service has a survey that is sent to people for them to complete, this is to gain information from people on their experiences with the services. Although these surveys have not been completed or returned at the time of the inspection. This meant that at the time of the inspection the service had no means of seeking people's views to further improve and drive the quality of care being received.

We met with the provider and registered manager on 29 June 2017 to discuss the shortfalls and concerns found during the inspection process. The registered manager told us that there were systems in place to assess and monitor, a safe and robust recruitment process and assessing and devising of person centred care records for people who use the service, these had not been used in their full capacity therefore the shortfalls had not been recognised. As part of our enforcement pathway we sent a letter of intent to the provider and registered manager on the date of 29 June 2017 asking them to provide an action plan on how they would be addressing the concerns that had been found during the inspection. Although the registered manager provided an action plan after our request for urgent information which was received by the Commission on 03 July 2017, the actions proposed were not robust and did not satisfy the Commission's

concerns about the effective and safe management of the service. The Commission is taking further enforcement action.

These failings are a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not carried out an assessment of needs that included preferences for care and treatment for people who used the service. The provider had not designed care or treatment with the view to achieve the people who use the service preferences and ensuring their needs were met.

The enforcement action we took:

Urgent Notice of Decision to impose conditions to the registration of Denise Quality Care Services Limited.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not assessed the risk to the health and safety of service users of receiving care or treatment. The provider had not ensured that persons providing care or treatment to service users had he qualifications, competence, skills and experience to do so safely.

The enforcement action we took:

Urgent Notice of Decision to impose conditions on registration of Denise Quality Care Services Limited.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have systems and processes established or operated effectively to prevent the abuse of the service users. The provider had not ensured that staff were competent in reporting incidents.

The enforcement action we took:

Urgent Notice of Decision to impose conditions on the registration of Denise Quality Care Services Limited.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems or processes established or operating effectively to assess, monitor and improve the quality and safety of the services provided. The provider did not assess, monitor and mitigate risks relating to health, safety and welfare of service users. The provider did not maintain accurate records for each service users.

The enforcement action we took:

Urgent Notice of Decision to impose conditions on registration of Denise Quality Care Services Limited.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have robust and effective recruitment processes in place for people employed by the service. Staff had not received relevant checks to ensure they were suitable to work for the service.

The enforcement action we took:

Urgent Notice of Decision to impose conditions on registration of Denise Quality Care Services Limited.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure the people employed by the service were provided with appropriate support, training, supervision and appraisals to enable them to carry out their duties safely.

The enforcement action we took:

Urgent Notice of Decision to impose conditions on registration of Denise Quality Care Services Limited.