DMC Signature Care Ltd

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Inspection report

Moulton Park Business Centre
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Northampton
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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

About the service
DMC Signature Care Ltd provides care and support to older people, younger people and children with a learning disability living in their own homes. On the first day of our inspection the service was supporting 25 people, however, only three adults and three children were receiving personal care. By the end of the third day of inspection all children had been supported to move to alternative care providers by the children's care commissioners.

Not everyone who used the service received 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 provider failed to have enough management oversight of the service to ensure all people received their care as planned in a safe way.

The provider's failure to have systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people led to children being placed at risk of harm due to unsafe transport and environments.

Vulnerable adults and children had been placed at risk of harm from staff that had not been recruited safely. The provider failed to follow their recruitment policies.

People did not always receive their planned care. The provider did not have systems to identify when people missed their care or received care from only one member of staff where two were required for safety.

The provider failed to have systems to identify, report and investigate safeguarding concerns. Staff did not always record the care they provided. The provider did not review the daily notes for information which indicated safeguarding concerns.

The provider failed to have systems to assess, monitor and identify where there was the need to improve the service. There were no audits to check people were receiving their care in a safe way.

Rating at last inspection
The last rating for this service was Good (published 16 August 2018).
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for DMC Signature Care Ltd on our website at www.cqc.org.uk

Why we inspected
We received concerns in relation to recruitment of staff. 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. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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.

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to recruitment of staff, managing risks, safeguarding and governance at this inspection.

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

Follow up
We will request an action plan for 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 as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

DMC Signature Care Ltd

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a registered manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We did not give the service notice of the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We visited the office on 5, 6 and 8 October 2021 and spoke with the registered manager and two office staff. We spoke with the relative of one person. We reviewed a range of records. This included six people's care

records. We looked at eight staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, rotas, daily notes and safeguarding records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We asked for further records to be forwarded to us which included policies and procedures, training and quality assurance records.

Inadequate

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 rated as good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- The provider failed to follow their own recruitment policies placing people at risk of receiving care form staff that the provider had not assured were of good character.
- The provider failed to check the identity of staff matched their documents. Two members of staff had been employed who had false documentation; the police have been informed.
- The provider failed to ensure staff had Disclosure and Barring Service (DBS) checks for their employment at the service. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.
- The provider failed to ensure they had collated and checked staff's full employment history with explanation for gaps in employment.
- Staff had provided details of referees that did not match their employment history. The references received did not always have contact details that matched previous employers, or correlate with the dates staff had declared they had worked. Staff did not have the required two references, of which one should be from a previous employer where staff have previously been employed to provide care.

The provider failed to establish recruitment procedures to ensure staff are safely recruited. This placed people at risk of harm. This was a breach of regulation 19 (1) (2) (3) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were at risk of not receiving their planned care as the rotas were not organised. The rotas showed staff were allocated to multiple calls at the same time. This meant people did not receive their care as staff were not allocated to them. There was no system to identify where people had not received their care.
- The rotas showed staff who had been suspended had been allocated to provide care; there was no system to ensure the rotas did not include staff that could not work.
- Staff who commenced working for the service since end of July 2021 had not received training. The training matrix and rotas showed these staff had been allocated to provide care without the necessary skills and competencies to provide safe care.
- Where people required two care staff, the log in details showed staff did not turn up at the same time. This meant people would not have been able to receive their care safely as they required two staff to maintain their safety.
- Staff did not always log when they arrived and left their calls. This meant there was a risk people did not receive their calls, as there was no system to check. Where staff did log into their calls, there were many occasions where the call was much shorter than the time for planned care, or care was provided many hours after their planned care times.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● The provider failed to adequately assess the risks of premises used for the care of children. Rotas and daily notes showed staff regularly took children to two premises to eat and be entertained. Children using the office space used the kitchen and toilet facilities shared with multiple other businesses. The office space contained toys, a kettle, microwave and a television. There were many hazards that had not been assessed relating to trailing wires, substances that could be hazardous to health and hot appliances and hot water. There was no risk assessment for the other premises used.

● The risk assessments for children travelling in cars did not mitigate the risks as the wording meant that cars should not be used. For example, the risk assessment stated, "Staff must not transport the children in their own vehicles, or registered cars provided by DMC." Staff did not have clear guidance of how to transport children.

● Children who were being transported in company cars were at risk of injury as there was no adequate system to check the company vehicles were safe to drive. The team meeting notes in September state there were four staff allocated to check the cars, however, there were no instructions or checklist to follow. One car was seized by the police as it was found to be unroadworthy.

● The provider failed to review assessments regularly or as people's needs changed. For example, one child's risk assessments had been reviewed in May 2020, their plan stated they should be reviewed in May 2021. The risk assessment and care plans had not been reviewed or updated to reflect their current needs.

● People's care plans guided staff how to mitigate risks did not always give safe guidance. For example, where the risk of scalding from hot water had been identified as a risk, the care plan stated the child should test the water themselves to make sure it was not too hot. This guidance would not have mitigated the risk of scalding and could have placed the child at risk of scalding.

Preventing and controlling infection; Using medicines safely

● There was no system to risk assess people's or staff's specific risks during the COVID pandemic.

● The provider had not instructed staff to take regular COVID tests. People were at risk of receiving care from staff that could not prove they were not infected with COVID.

● One person received their medicines from staff. The provider did not provide any evidence staff had received training in the safe management and administration of medicines.

The provider failed to adequately assess or mitigate the risks to the health and safety of service users; Provide safe medicines management; Assess, prevent and control the spread of infections. This placed people at risk of harm. This was a breach of regulation 12 (2) (a) (b) and (h) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The provider failed to have adequate systems to identify, record and take steps to prevent abuse.

● Staff did not always record what care they had provided in the daily notes. There were occasions where staff had logged into calls, but there was no corresponding daily note. There was a risk information about events during care would not be recorded and acted upon.

● Staff had recorded incidents in daily notes where it was evident children receiving care and members of the public had been subjected to verbal and physical abuse from children receiving care. These incidents had not been recorded to include the names of the victims and had not been identified as a safeguarding incident. This meant these incidents had not been reported to the local safeguarding team.

● Where safeguarding alerts had been raised by others, the provider had not always provided accurate information about who they provided care for, or who they employed to the safeguarding team. This placed people at risk of harm as the safeguarding team did not have all the information they required to ensure all safeguards were in place.

● Most staff had received training in safeguarding vulnerable adults and children. Three new staff who had been employed since the end of July 2021 had not yet received their safeguarding training.

The provider failed to establish and operate systems and processes to prevent abuse of service users and effectively investigate any allegation or evidence of such abuse. This placed people at risk of harm. This was a breach of regulation 13 (2) (3) (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider failed to ensure there was sufficient management oversight of the service to ensure all people received their care as planned in a safe way. During the inspection the registered manager did not know how many people were receiving personal care or provide a complete list of all staff employed. New staff had not received training; they had been deployed to provide care.
- The provider failed to have systems and processes implemented to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This had led to children being transported in cars that were not roadworthy and children being cared for in environments that had not been assessed for risks; posing risks to their safety. People's risk assessments had not been reviewed for accuracy; they contained contradicting information which did not give clear guidance to staff on how to mitigate the known risks.
- The provider failed to follow their own recruitment policies or have oversight of the recruitment of staff. They failed to audit the content of staff employment files which would have told them staff had not been recruited safely. This had led to vulnerable adults and children receiving care from staff that had been employed with false documents, inappropriate references, no criminal checks or adequate employment histories.
- The provider failed to have systems to assure themselves that people always received their planned care. There was no oversight of the rotas to ensure staff were allocated to provide care or that staff turned up to provide care at the agreed times. People were at risk of not receiving their planned care as there was no reliable system in place to identify if people received their care. Where staff had not logged into their calls, there was no system to identify whether these calls had taken place.
- The provider failed to have a system to review people's daily notes to assure themselves people were receiving their planned care and check for incidents and complaints that needed action. This led to incidents not being reported to the local safeguarding team.
- The provider failed to have systems and processes in place to assess, monitor and identify where there was the need to improve the service. There were no audits of the rotas, daily notes, recruitment files, company cars, risk assessments or care plans. This meant the provider did not have the assurances they were providing safe care or know what was required to drive improvements.

The provider failed to have all the systems and processes implemented and embedded to assess, monitor and improve the quality and safety of the service and assess, monitor and mitigate the risks relating to health and safety. This placed people at risk of harm. This was a breach of regulation 17 (2) (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 did not demonstrate they understood their duty of candour responsibilities as there were no systems in place to reliably report and feedback the progress of investigations to people involved.
- The provider had failed to notify the Care Quality Commission of safeguarding alerts.
- Accidents and incidents were not always logged and shared with appropriate professionals; this meant actions were not taken to reduce any further risk.
- Accidents, incidents and near misses were not reviewed which meant the provider failed to have the information they would need to share with staff and use to drive improvements in care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The registered manager worked closely with the local authority children's team. Feedback from the team showed the service had struggled to provide staff over the school holidays, and poor communication with the children's team and children's relatives. The registered manager had not attended all the required meetings and a plan had been devised for improving these issues.
- The registered manager held staff meetings regularly. However, the content of the meetings did not provide information for staff to share and learn from incidents.
- Where the registered manager had sought feedback from relatives, the feedback was positive, but undated.

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 The provider failed to adequately assess or mitigate the risks to the health and safety of service users; Provide safe medicines management; Assess, prevent and control the spread of infections. This placed people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to establish and operate systems and processes to prevent abuse of service users and effectively investigate any allegation or evidence of such abuse. This placed people at risk of harm.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to have all the systems and processes implemented and embedded to assess, monitor and improve the quality and safety of the service and assess, monitor and mitigate the risks relating to health and safety. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice which required the provider to be compliant by 16 December 2021.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to establish recruitment procedures to ensure staff are safely recruited. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice which required the provider to be compliant by 30 November 2021.