Supreme Care Services Limited

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Inspection report

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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

The inspection took place on 15, 16 and 17 August 2017 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service for adults; we needed to be sure that someone would be in. Supreme Care Services provides personal care to people living in their own home. The service provides care and support for older adults, people with disabilities and people living with dementia. At the time of our inspection there were 181 people receiving care. This was the first inspection of the service since it was registered in April 2017.

There was a registered manager at the service at the time of our 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.

There were not sufficient numbers of staff deployed to meet people's needs. There were high levels of calls to people's homes that were missed or where staff arrived early or late or did not stay for the allocated amount of time. This meant that people missed meals and medicines.

People were not protected from risks to their health and wellbeing because risks had not always been identified and were not detailed enough to guide staff about how to manage specific risks. Not all staff were aware of the risks people faced and people's relatives did not always feel their loved ones were safe and expressed concern about risk management.

Medicines were not managed properly. People reported that medicines were sometimes missed and there was not an effective monitoring system in place to check they were being administered safely.

The provider did not ensure that people were treated with dignity and respect. People and their relatives told us that this affected their wellbeing.

The service was not organised in a way that promoted safe and quality care through effective monitoring systems. People and their relatives were not confident with the management of the service and told us they were not always able to raise complaints and did not always feel their concerns were listened to.

The provider had not done all that was reasonably expected of them to promote good practice following a serious allegation of abuse. Staff were aware of the safeguarding adults procedure however, the policy did not contain relevant contact details for outside agencies. The provider could not be assured that staff were suitable to work in the caring profession as criminal record checks had not been obtained prior to staff starting work at the service.

People were not always supported to eat and drink enough when visits to people's homes did not take place

as planned for staff to support people with their meals. Relatives reported staff did not always prepare meals safely. People's care plans did not always contain enough guidance with staff about nutrition.

The provider followed the latest guidance and legal developments about obtaining people's consent to care. People or their relatives had signed care plans to indicate their involvement in care planning.

People's relatives reported that staff were not adequately trained to work with people with dementia. Staff received the provider's mandatory training and also completed the Care Certificate. Newly appointed staff were supported in their role by an induction period.

People were supported to access healthcare professionals when they became unwell.

We found six breaches of the regulations around staffing, respect and dignity, safe care and treatment, person-centred care, safeguarding adults from abuse and good governance. We made three recommendations in relation to complaints, training and meeting nutritional and hydration needs. Full information about CQC's regulatory response to any concerns found during inspections is added to the back of the full version of the reports after any representations and appeals have been concluded.

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.

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. There were not enough staff deployed to meet people's needs.

Risks to people's health and wellbeing were not always identified and assessments did not provide enough guidance to staff about how to mitigate against them.

Medicines were not managed in a safe way.

The provider had not done everything reasonable to protect people from the risk of abuse.

The recruitment procedure was not effective and did not ensure staff were suitable to work in the caring profession.

Is the service effective?

Requires Improvement

The service was not always effective. Staff received standard training and support relevant to their roles but people's relatives had concerns about their knowledge around dementia.

Staff did not always support people to eat and drink enough.

The service was committed to working in line with the Mental Capacity Act (2005) but had not always obtained lasting power of attorney documentation, where this had been identified.

People were supported to access support from health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring. Staff had not always developed compassionate relationships with people and did not treat people with dignity and respect.

The provider had an inconsistent approach about supporting people with their independence and religious and cultural needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care documentation was not always detailed or tailored to the individual to enable staff to carry out care in line with their preferences.

Care staff did not always demonstrate that they knew people well.

People and their relatives were not always confident they could raise concerns or their concerns would be listened to.

People and their relatives were involved in planning their own care.

Is the service well-led?

Inadequate

The service was not well led. Monitoring systems were limited, incomplete and not fit for purpose and did not identify the concerns found during the inspection.

Communication methods to staff and people were not effective.

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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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 15, 16 and 17 August 2017 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and staff are often out during the day; we needed to be sure that someone would be in. The inspection was conducted by two inspectors.

Before the inspection we reviewed the information we held about the service and statutory notifications about events that affected the service including one relating to the allegation of physical abuse perpetrated by a member of care staff.

During the inspection we spoke with the nominated individual, the registered manager, two care coordinators, the call monitoring office and the office administrator and the office administrator. We spoke to five members of the care staff. We looked at 15 people's care records, and five staff files, as well as records relating to the management of the service.

After the inspection we made telephone calls to two people who use the service and 18 relatives.

Inadequate

Is the service safe?

Our findings

People's relatives did not always feel the service was safe. One relative said, "I would never leave her alone [when care was provided]". Another told us about a particular incident and said, "I was worried about [my family member's] safety."

People were not protected from risks to their health and wellbeing. Relatives had concerns about people's safety and told us, "They don't always know how to support mobility issues." And, "I was worried about [my family member's] safety… [The care workers] were aware of the risks but did what was more easier for her rather than ensure there was no risk. Because of the urine on the floor [my relative] could have slipped."

The provider had not assessed all risks people faced and assessments available did not include comprehensive guidance for staff about how to mitigate identified risks. Documentation was not easy to navigate as risks were mainly presented in checklist form and provided conflicting information about people's needs. For example, one person had been identified as being at risk of pressure sores however the assessment gave conflicting guidance. In one section the assessment stated treatment is given by the district nurse, however, the care plan later stated, "Care worker should always apply cream on the areas always [sic]." No further information was included about the cream or areas involved.

Another person's assessment stated they needed to be repositioned at each visit. However, there were no records in place to ensure the person was turned into a different position to relieve pressure. A risk assessment in relation to falls simply stated, "Risk of falling: Carer to supervise" with no further detail provided. For a third person, the risks associated with living with diabetes had not been assessed and there was no information for staff about what to look out for if the individual developed high or low blood sugar levels or what action must be taken to minimise the risk to that individual. A fourth person's risk assessment had not been reviewed or updated after a serious allegation of abuse had been made. The registered manager agreed that it needed updating but had decided not to do so pending a development in the case.

Staff understanding of the risks people faced and how to prevent them varied. Some staff we spoke with could not identify risks experienced by the people they supported. One member of staff told us they did not always find the risk assessments useful. They stated, "Sometimes they're ambiguous. There's a level of ambiguity there. You don't have time to really study them. At the same time you're trying to get the meal ready so you might not understand what you need to do. You can't ask 'What does this section mean?'"

Medicines were not managed in a safe way. People and their relatives told us they were not supported with their medicines on time or at all when care workers were late or missed visits. Other than in one instance, there were no records held at the office about medicine errors. Care staff were not supported by clear written guidance and there was no information about side effects of specific medicines in people's care records. The provider could not be assured medicines were properly managed because there was no system in place to routinely collect and audit medicine administration records (MAR). Six MAR were provided for review during the inspection ranging from May to July 2017. These contained errors such as medicines being signed as given on the 31 June even though the date does not exist. One MAR chart appeared to have been

filled in by the same person for the whole month even though different care workers attended the calls throughout the month. Incorrect codes were used on the MAR charts reviewed. None of these errors had been identified by the service and no action had been taken to ascertain whether people had had their medicines or to stop these errors being made in the future. There was a discrepancy between the registered manager's understanding of the amount of people supported with the management of their medicines and what people told us. This meant the service was not ensuring that medicines were managed in a safe way as records were unclear and inaccurate.

The issues above relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure there were enough staff deployed to meet people's needs. People and their relatives told us staff were unreliable. They stated staff frequently missed visits, were too late or too early, did not stay for the allocated amount of time, two members of staff did not always attend when required and the members of staff who supported them were too inconsistent to provide continuous support. It was reported that people missed meals and medicines, were 'put to bed' too early or supported out of bed too late.

Relatives reported people were left in soiled clothes and bedding or remained in pyjamas for medical appointments. People's relatives described how this impacted negatively on their wellbeing including making them feel "stressed", "confused", "embarrassed" and "angry". For example a relative told us, "In the morning appointment they are not turning up till 10 or 11 o'clock. So [my family member] is waiting for them to make breakfast before [they] can have the medicines. It stresses [my family member] out because [they] wonder where they are because [they] like routine." Another reported: "[My relative] is a diabetic… [They] need that medicine to keep [their] blood sugar level correct. They didn't turn up this morning and if I didn't go I don't know what would have happened." Another told us, "Last week, we have a double up package, only one carer came. I told the office and they didn't help us at all."

The provider had recently implemented an electronic monitoring system where care staff logged in and out of people's homes in real time. This had been introduced two months prior to the inspection and a monitoring officer had been employed the week before the inspection to report on missed visits Records showed only 9 calls had been made at the scheduled time for that day. Calls were frequently made either very late or early with one made 125 minutes late and another 77 minutes early. Care staff frequently had not stayed for the allocated amount of time. The registered manager stated the call times differed from those in people's care plans because people wished care staff to attend at a different time and the service was flexible and meeting those requests. The registered manager could not explain why the care plans had not been updated to reflect these changes. However, feedback from relatives of people was that they had concerns about the punctuality of staff. Log books were not routinely brought back to the office so recorded times could not be monitored. This meant it was not clear people were receiving the amount of care they needed at the time of their choosing.

The above three paragraphs relate to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of potential abuse. Staff had received training in safeguarding adults and children from abuse but understanding of what may constitute abuse and how to identify it differed between the staff we spoke with. For example, staff were not always aware that people could be at risk of financial abuse. Staff were aware of their duty to report any concerns to their manager and escalate concerns where necessary, "I report it to my manager straight away. Whenever you have any

problems you call on your manager and they take immediate action. Immediately the social work team takes action. If they don't do anything, I would report it to higher level and then do anonymous whistleblowing and tell the Care Quality Commission." The policy in place to guide staff about how to escalate their concerns was out of date and contained contact details for the safeguarding team in London Borough of Kingston rather than the Hackney and Newham teams. Following a serious allegation of abuse no action had been taken by the provider to make the care staff aware of what is required of them in terms of safe practice and conduct.

The issues above relate to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of harm because the recruitment process was not always safe. The provider could not be assured that people were supported by staff who were suitable for work in the caring profession. Two staff files showed the staff members had commenced work under a TUPE arrangement without the provider ensuring they had seen their current criminal checks via the Disclosure and Baring Service (DBS) to assess their suitability for work. The DBS is a check to see if prospective staff have any criminal convictions or are on any list that bars them from working with vulnerable adults. This meant the provider had not assured themselves that staff were suitable to provide care. Relevant employment history, right to work, references and criminal record checks were held on file for the other staff documentation reviewed. The registered manager stated they would address this issue.

Requires Improvement

Is the service effective?

Our findings

Staff were not always provided with adequate training to meet people's care and support needs. One person told us, "They are already trained and they are good to do the job properly." However, relatives told us, "It's the way carers are treated, they send inexperienced people in." A second relative told us, "Training around dementia is poor." A third told us, "No I don't think they've had the right training regarding dementia." We reviewed the training schedule held by the provider and noted that 31 of 62 staff working in the London Borough of Hackney had not received all of their refresher training in line with the provider's requirements. Refresher training included modules such as safeguarding training. 12 out of 62 members of staff working in Hackney had not received the provider's mandatory training in awareness of mental health, dementia and learning disabilities. We also noted that a member of care staff we spoke with was not included on the training schedule so the provider could not be assured their training was kept up to date. However, after the inspection we were shown the training certificates and noted the member of care staff's training was up to date.

The issues above relate to a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff were supported in their roles by regular supervision sessions. Newly appointed care staff underwent an induction period and told us they spent five days shadowing more experienced staff members.

The provider did not do all that was reasonable to support people to eat and drink at planned times and in line with their preferences. Relatives of people living with dementia told us that staff were not aware of how to support the person to eat and drink. One relative told us, "When my [relative] says [they are] not hungry they listen to [them] but that's what people with dementia say. And they don't heat it properly. They don't offer an alternative like fruit…That's not in the care plan."

Other issues reported included people not getting meals when the call was missed and care staff not knowing where food was stored in people's homes or how to prepare it. For example, one relative told us, "[My family member] didn't get any food. They didn't come. When you're relying on someone to come in it's frustrating. They come when it suits them not when it suits [my relative]." A second relative said, "Unfortunately sometimes they are not sure what to do with it. They are not sure what goes with what. Sometimes they say they can't find it, we put in the fridge." Care records we reviewed were not always explicit about what staff were responsible for in terms of food preparation and at times the guidance differed from the support people told us they received. The registered manager agreed that the care records required more clarification.

We recommend that the service seek advice and guidance from reputable sources about meeting people's hydration and nutrition needs.

People's rights were protected as staff understood their responsibilities under the Mental Capacity Act 2005

(MCA). The 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in domiciliary care agencies are to be made to the Court of Protection.

Where there was a good working relationship between the care staff and person using the service, people were supported to live their lives in the way they chose. People told us they made decisions about their care, "They give me choices." Care staff were aware of their responsibilities under the MCA and how to apply its key principles to their role. A member of care staff told us, "I ask them what they want and if they don't want to do something I encourage them and crack jokes and they do it because I give them reasons. Later I would come back to it if they don't want to, I don't force them."

We noted that capacity assessments were completed by staff and people or their relatives had signed their care records indicating their consent as appropriate.

People were supported to access health care. People and their relatives gave examples of when care workers had reported concerns to office staff and relevant appointments had been booked. One relative said, "They usually ring the GP." There was evidence in people's care records that the service had corresponded with healthcare professionals such as district nurses and GPs. Staff were aware of situations that may impact adversely on people's health and gave examples of when they had made requests that other healthcare professionals attend to help the person showing signs of deterioration.

Requires Improvement

Is the service caring?

Our findings

Not all staff had developed caring relationships with people using the service. Relatives told us that staff did not always treat their family members with respect and did not take the time to talk to them. One relative said, "My [family member] said 'Good morning' and the care worker ignored her. It was only when I got up and that it was because I was there that she then answered her. The carer had put my [relative] to bed and was making food for herself to take home…. My [relative] had had an accident as she's incontinent. The carer had put a sheet over the accident and said 'I'm off'' and she was supposed to be there for an hour."

Relatives gave examples of care staff who were unkind or aggressive when speaking to people, "They're ok. We had one that was a bit aggressive last month and they changed the carer. Her voice was a bit loud and shouting not normal not right and we informed them and they dealt with it." Another relative said, "The morning carer does talk to [my relative] but the other carers don't even talk to my [relative]. They just come in. I've heard them saying 'come on get up the stairs!'". One member of staff we spoke with used inappropriate language about people who use services as a group who portray behaviour which may challenge the service. The member of staff said, "Some service users are really horrible and can say some things that have been extremely offensive. You just have to stomach. SU have been put way up there."

The provider had not assured themselves they had done all that was possible to support people to express their views so care staff could involve them in day to day decisions about their daily lives and support. In two instances people and their relatives told us that care staff spoke a different language to themselves so they could not communicate effectively. A person explained how this created problems during personal care and that it caused them to be "stressed." A relative told us, "I am not 100 per cent happy with all the carers. They've taken away [my relative's] carers [from a particular culture]. There is a language barrier now. We had one carer yesterday, she turned up and she was early so she sat and fell asleep on the sofa. I wouldn't leave them alone with her because of the language barrier." Care records did not always contain instructions for staff using terminology that promoted dignity and respect. Care records contained the heading, 'Does the service user accept and cooperate with instructions?' This language did not reflect the person's autonomy nor did it highlight the importance of maintaining an open dialogue when supporting people to ensure they could do what they wanted each day.

People's independence was not always promoted. Care records did not provide staff with sufficient guidance about how to support someone to do what they were able. For example one record we reviewed stated, 'To continue to be independent for as long as possible." A relative told us, "You're here to help her do as much as she can for herself but they don't, they take over."

The issues above relate to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's diversity and privacy was promoted at times. Care files captured people's first language and religion. Staff gave examples of how they supported someone to practice their religion by getting them ready earlier to attend their place of religious worship. The provider had made a limited attempt to match

people with care staff of a similar background. The provider ensured people's privacy by allocating a care staff member of the person's preferred gender. Care staff gave examples of how they supported people's privacy.

Requires Improvement

Is the service responsive?

Our findings

The provider was inconsistent at assessing people's needs and planning care. People's care plans were developed following the review of the local authority documentation and an assessment by a field care supervisor. People's care and support needs were written in very brief care plans. People were involved in planning their own care where appropriate and had signed to evidence their involvement. Relatives stated the provider involved the family where appropriate. A care coordinator stated, "We involve service users: Those that have capacity to decide for their own care. They can decide what's in it. Next of kin can be involved as well. The plan is based on them. They have preferences we take that on board different choices." Staff found those care plans that were robust useful, "They are very useful. They tell me about the clients what choices he wants. His allergy their hobbies, diet. What you need to do for them."

However, the personalisation contained within care records was inconsistent. Records were not always written from the first person where appropriate and did not always contain sufficient details of their personal preferences and circumstances. For example, one person's care record said, 'Eating needs to be encouraged'. A second person's stated 'support with personal care'. At times care records contained contradictory information about people's histories or likes and dislikes such as whether they had children or not.

Care staff gave examples about the support they offered when someone's needs changed around their health preferences. However, records we reviewed demonstrated that people's needs were not always re-assessed and recorded when these changed, such as around supporting people to eat and drink and where there was a risk to someone's wellbeing.

The issues above relate to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives did not always feel they were able to raise a complaint or that they would be listened to. A person told us, "I could not get through to the office." A relative told us, "We were told they would call back. They didn't." Another relative said, "They're not brilliant. They're a bit slow to act on requests and coming back to us. It's very difficult to get hold of them. Out of hours is a problem. No-one picks up. And we're told they're busy."
Records showed where people had been able to make a formal complaint they reported action had been taken. The provider had recorded eight formal complaints since their registration and we noted seven of these had been dealt with and appropriate action taken such as removing care staff. However in one case the action to monitor a staff member more closely had not been complied with.

We recommend the service seek advice and guidance from reputable sources about removing the barriers people and their relatives face when raising concerns about service delivery.

Inadequate

Is the service well-led?

Our findings

The service was not organised in a way that promoted safe care through effective quality monitoring. The monitoring systems in place were inconsistently applied and ineffective. For example, the system to collect and audit medicine administration records or log books to check for errors in care and medicine administration was chaotic and not complied with. Training scheduling systems were inaccurate. Criminal records screening was not fit for purpose. The provider audited care records but these did not assess the quality of risk assessments or level of personalisation contained, so any areas that needed improvement were identified and addressed.

The provider had carried out regular spot checks at people's homes but these did not include comprehensive dignity and respect assessments. As a result they had not been successful in identifying staff's behaviours in the way they engaged and interacted with people to promote a caring relationship between staff and people. The provider had not carried out an internal inspection of the service to assess the quality of the service provided to people and compliance with relevant legislation and guidance in order to identify shortfalls and to draft an improvement plan. There was no attempt at tracking trends in complaints or safeguarding concerns to prioritise service-wide areas requiring critical improvement. The concerns found at the inspection had not been identified by the provider and as a result they were not aware of all the areas they needed to improve and there was no recorded plan to address the shortcomings.

The service was run by the registered manager and five care coordinators. People and their relatives felt the service was not well managed. Typical comments included, "I would look at the management. It is poor." And, "The problems in the office are severe". The provider had not adequately gained feedback about the service from people, their relatives and associated health and social care professionals. The registered manager informed us that questionnaires would be sent to these stakeholders on an annual basis. Telephone calls were made to gather people's views yet people told us they could not always contact the service when they had a problem or wanted to make a complaint. People and their relatives felt that although their concerns may be addressed initially they would face a similar problem at a later date and the service was not improving. A relative said, We are willing to give people a chance but when it happens again and again. We just want good service."

Internal communication systems for the registered manager to set the tone of the organisation and highlight organisational priorities were not always effective. Two staff meetings had been held since the registration of the service in April 2017, the first covered safeguarding information. However, urgent correspondence, meetings or internal training had not taken place in response to a serious allegation of abuse in order to remind people about their duties and appropriate behaviour and conduct, and so learning could take place to prevent a similar incident from happening again.

The issues above relate to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff reported good working relationships with the registered manager and office team. Staff described

them as "approachable". One member of staff stated, "They are good. They are approachable. There is enough support." It was noted that supervision sessions were up-to-date.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs and did not reflect their preferences. The provider had not carried out an assessment of the needs and preferences for care and treatment of the service user. The provider had not designed care with a view of achieving service users' preferences and ensuring their needs are met. Regulation 9(1)(a)(b), (3)(a)(b).

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment because systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13(1)(2).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons must deployed. Persons employed by the service provider in the provision of a regulated activity did not receive such appropriate support, training, professional development as is necessary to enable them to carry out the duties they are

employed to perform. Regulation 18(1), (2)(a).