Glory Comfort Care Ltd

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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

This inspection took place on 17 May 2016 and was unannounced. This was the first inspection since the provider registered with us in 2014. We had received some concerns regarding the service with regard to the provider and how the service was managed. We completed this inspection and found that care being delivered was not safe and people were at risk of harm due to the ineffectiveness of the management. We have judged this service as Inadequate and placed the service into special measures. We asked the provider for additional information regarding the recruitment processes and training for staff. We have also begun enforcement action against the provider.

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.

The service provided people with personal care and support in their own homes. There was one person using the service at the time of this inspection.

The service had a registered manager. 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 registered manager is also the registered provider and will be referred to as the 'provider' throughout this report.

The provider did not have robust recruitment procedures in place, to ensure staff were suitable or eligible to work and to provide safe support to people. Staff did not receive the training or supervision they needed to be able to support people in a safe or effective way. There were sufficient staff to provide care and support however some staff were recruited that did not have the necessary values and behaviours to work with people.

People's medicines were not managed safely, guidance for the safe administration of some medicines was not available for staff and sometimes people's prescribed medicines were missed.

Effective systems were not in place to assess, monitor and improve quality and manage risks to ensure people's safety, health and wellbeing.

The provider did not notify us of events that affected the service provision.

People were not consulted on a regular basis to ensure the support being delivered continued to meet their needs. The care and support package was not regularly reviewed to ensure it met people's needs. Risk assessments were completed; however the person they related to was not included in the assessment.

Staff did not always express a caring attitude when working and referring to people who use social care services.

The provider did not have a complaints procedure; people would not know how to make a complaint if they wished to do so.

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. Recruitment procedures were unsafe and ineffective. Medicines management was not safe, staff were not trained to administer medicines and guidance was not available. There were sufficient staff to provide care and support however some staff were recruited that did not have the necessary values and behaviours to work with people. There was a safeguarding adult's procedure but not all staff had received training. Risk assessments were completed; however the person they related to was not included in the assessment.

Is the service effective?

Requires Improvement

The service was not effective. Staff had not been provided with training or received supervision to fully meet people's needs and promote people's safety, health and wellbeing. The principles of the MCA were followed.

Is the service caring?

Requires Improvement

The service was not caring. Some staff were disrespectful in their approach to working with certain groups of people. People who used the service were not actively involved in agreeing and review of their care package.

Is the service responsive?

Requires Improvement

The service was not responsive. People were not consulted on a regular basis to assess whether their support needs had changed and the care package remained suitable. There was not a complaints procedure; people would not know who to speak with if they had concerns.

Is the service well-led?

Inadequate

The service was not well led. No systems were in place to monitor and review the quality and safety of the service. Statutory notifications had not been submitted when events had occurred that affected the safety and wellbeing of people.

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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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 17 May 2016 and was unannounced. The inspection team consisted of two inspectors.

We reviewed information we hold on the service. We spoke with the provider, an administration officer and the local authority. We did not speak with any carers, the person who used the service or their representatives as they were unavailable. We looked at one person's care records, staff recruitment procedures and the systems the provider had in place to monitor the quality of the service to see if they were effective.

Inadequate

Is the service safe?

Our findings

We looked at the way the service managed people's medication. We saw that the person who used the service required support and prompts to take their prescribed medicines at set times during the day. The care calls corresponded with these times so that the person could be supported with their medicines. We saw there were occasions when the call to the person's home had been missed. The provider told us they were aware of one instance when this person's call was missed, therefore the person did not have their medicines. The provider did not tell us of any action they had taken to mitigate any ill effects of the person not having their prescribed medicines. This meant the person would not receive their medicines as prescribed as they required support and promoting to take their medicines.

We saw on the person's daily notes that an occasional medicine was administered to them upon their request. The provider could not confirm and we could not establish if this medicine was a prescribed or over the counter medicine. We asked to see the instructions and guidance available for staff as to the safe administration of the occasional medicines. The provider told us that no written guidance was available. They told us: "We just give it when the person requests it and write in the daily notes that we have given it". The provider told us that staff who supported the person had not received training in the safe administration of medicines. This meant that the person was at risk of receiving medicines by untrained staff and in an unsafe way.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the provider's recruitment processes. We looked at 14 staff personnel files. Of the 14 files, 10 did not have references, either character or professional, seven did not have an employment history and one potentially did not have a work permit. One file contained a residency permit that had expired. We spoke with the provider about our findings, they said: "Well no more shifts for them then". This meant that the provider was not ensuring staff were of good character or eligible to provide care and support to people who used the service.

We asked to see the Disclosure and Barring Service (DBS) check for one employee, the provider told us there was not one but they (the provider) had seen a DBS check from a previous employer. They were also unable to find this document. This DBS check or any reference to the check was not available. The DBS is a national agency that keeps records of criminal convictions.

We asked to see the personnel file of the main carer for the person who used the service. The provider eventually confirmed that: "No records were available". This meant that people were at risk of receiving care from unsuitable people because the provider did not have a robust recruitment process.

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

Not all staff had received training in safeguarding adults from abuse. We saw that one person had received this training in 2016. The provider was unable to tell us how many staff had received safeguarding training as they did not have a training planner or record. We saw a poster displayed in the office of the local area safeguarding teams contact details. The provider showed us their safeguarding procedure but we could not establish how many staff had seen and read it. We asked the provider if they had notified the safeguarding team following the missed call and missed medication incident, they confirmed a referral had not been made. This meant that incidences of potential abuse were not investigated in a formal way, people who used the service were at risk of abuse.

Risk assessments had been completed where risks to people who used the service were identified. For example, the self-administration of medication, the environment which included infection control risks and moving and handling. We could not see that the person or their representative had been involved with discussing these risks. The records did not include any reference to discussion with people.

Requires Improvement

Is the service effective?

Our findings

We saw that the support plan for the person who used the service contained details of the support they required during each of the calls. This included the level of support they required in relation to meal preparation and their prescribed medicines. The daily report completed by the carer following each call detailed the time of the call, the welfare of the person and the support provided. This meant carers were able to see the actions taken on previous visits. The support plan was completed by staff there was very little evidence of input from the person or their representatives.

We looked at the support plan of the person who used the service. It included the support they needed from the carers with preparing a drink and sandwich of the person's choice. The person also required support with taking their regular prescribed medication. We saw on the daily notes that staff provided the person with these support needs. The provider told us that food safety and handling was included in the induction training, but confirmed the carers had not received training in medicine administration. We did not see any training certificates or training details for either of the two main carers in food safety or medication management. This meant the person was at risk of harm due to support being provided by untrained staff.

The provider did not have a training plan to ensure training for staff was identified, available and offered. We saw staff had received induction training which included 'activities of daily living, moving and handling, carer's responsibility and carer's personal presentation'. Some staff had enrolled for training for the care certificate. The provider was unable to tell us how many carers had completed this.

The provider told us that the carers received supervision every four to six weeks and that spot checks on their work were completed at intervals. We did not see any record of supervision sessions or spot checks in the files we looked at. The provider confirmed that no records were completed. This meant that staff were not adequately supervised or checked to ensure they provided support to people safely and effectively.

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. The provider told us that the person who used the service was able to make some decisions for themselves but at times became 'confused'. We saw that the person had given permission for their family members to act on their behalf. Family members had signed the consent forms for carers to administer medication and provide support.

The provider told us that the family members of the person who used the service generally supported the person with their health care needs. The provider told us the carers had been instructed to phone the office, the person's representatives, the doctor or the emergency services if they identified that people were ill.

Requires Improvement

Is the service caring?

Our findings

We saw that some people had been employed that did not show or demonstrate they had an aptitude for caring. For example we saw an application form had been completed with the reason why the person wanted to work at the service. This contained some inappropriate and disrespectful language but the person was nevertheless employed. There was reference to 'my experience with oldies' and 'we all know how difficult, hard and stressful old people are'. This shows that the person did not have the correct values and behaviours to work with people who required social care and support.

We saw a document 'Rules and Regulations of Glory Comfort Care', this included instructions for staff not to call the office after 5pm or at weekends 'only if really urgent'. And 'remember to cover your back by being professional ……...never engage yourself in unnecessary gossip'. The necessary values and behaviours for caring and supporting both the staff and people who used the service were not demonstrated by the management.

Throughout the inspection at the office we heard the provider answer the phone in a polite manner. They told us that some carers were due to arrive at the office for 'induction'. We saw a group of people arrived during the afternoon but we were unable to establish the reason as they were quickly seen off the premises by the provider.

The family of the person who used the service were involved with agreeing the care package and the continuing support provided. We did not see that the person was actively involved as the documents that were signed were signed on the person's behalf by family. The provider told us the person and their representatives were involved with the care planning process but did not record their inclusion or involvement.

Requires Improvement

Is the service responsive?

Our findings

Prior to the person being offered a care package information was received from an assessment of their needs. The care plan was then formulated from this assessment. The support plan had not been reviewed or updated since the package was initially agreed. The provider told us this was not needed as there had been no changes to the level of support needed. However there was nothing recorded to suggest that any discussion had taken place with the person or their nominated representative.

The support plan included the tasks the person could undertake independently and those for which they required support. For example they preferred to have a sandwich of their choice and prompts to take their medication at certain times during the calls. Information was also available for the support available to the person from family members. The provider told us they had regular contact with the person and their family but did not record any occasions when contact was made.

The provider told us they had not received any complaints regarding the service. We asked to see the provider's complaints procedures, they tried to locate the procedure in the policies and procedures folder but was unable to do so. This meant that people wishing to complain about the service would not be aware of how or to whom they could raise their concerns.

Inadequate

Is the service well-led?

Our findings

The provider was unable to tell us how they assessed the quality and safety of the service. We asked the provider to show us their training programme, quality monitoring documents, complaints procedures and log, staff supervision and appraisal plan, service user and relative feedback, incident and accident records, safeguarding referrals and statutory notifications. The documents we asked to look at for inspection purposes were either unavailable or difficult to locate. The office was disorganised, the provider had difficulty finding any information in a timely way.

We saw that carers had not received the necessary training or had their character or employment status checked through the recruitment processes. The provider employed people who were unsuitable to work and to provide support to people who used the service. Staff were not adequately supervised, did not display the right values and behaviours towards people and referred to people in a derogatory and offensive way. People were at risk of receiving care and support from untrained and unsuitable staff.

The provider told us they made contact with people who used the service and their representatives on a regular basis either in person or over the telephone. They confirmed no records were made of this contact.

We asked to see the provider's plan for the training and development needs of the carers. We saw that all the personnel files contained a certificate for induction training. This training included 'activities of daily living, moving and handling, carer's responsibility and carer's personal presentation'. The provider told us that some carers had enrolled in training for the care certificate in October 2015. They had a set timeframe to complete the course. The provider was unable to tell us how many carers had completed this. We did not see any care certificates in the staff personnel files we looked at.

The provider registered with us to provide a service to people living with dementia, mental ill health and a learning disability. In the personnel files we looked at we saw no reference to training in these or any other service specific topic. Staff had not received the necessary training needed to provide a safe and effective service.

We looked at the support plan of the person who used the service. It included the support they needed from the carers with preparing a drink and sandwich of the person's choice. The person also required support with taking their regular prescribed medication. We saw in the daily notes that staff provided the person with these support needs. The provider confirmed that the carers had not been trained in the safe handling of food or medication administration. This meant the person was at risk of harm due to support being provided by untrained staff.

The new starter information document dated January 2016 included a section on 'supervision sessions'. 'All staff working with Glory Comfort Care will be given the opportunity to hold a supervision session with their line manager every eight weeks, an appraisal will be held every 40 weeks to reflect on your working practice, focus on training needs and discuss any concerns you may have on a1:1 level'. The provider told us that the carers received supervision every four to six weeks and that spot checks on their work were completed at

intervals. We did not see any record of supervision sessions or spot checks in the files we looked at. The provider confirmed that no records were completed.

The provider told us that there had been an occasion when the person did not have their medication due to a missed call. We saw that there were three missed calls to the person who used the service. The provider told us the calls were covered by either the other allocated worker or the provider themselves. We were unable to establish if the calls had been covered, the provider was unable to show us any record of the calls being made over this period of time. The provider had not referred this incident to the local authority as they were required to do.

The above evidence shows effective systems were not in place to assess, monitor and improve quality and manage risks to ensure people's safety, health and wellbeing. This constitutes a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. A notification is information about important events which the provider is required to send us by law. The provider was not acting within the correct procedures in relation to their registration of the service. We were not informed of any safeguarding concerns, missed calls or missed medication. The provider was unaware of her responsibility to do so.

This constitutes a breach of Regulation 18, (1), (2), (e), (f), of the Care Quality Commission (Registration) Regulations 2009.