Quality Nursing Ltd

Quality Nursing LTD

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an announced inspection on 7,12, 20 July and 3 August 2016. Following this, we spoke with people who used the service and members of staff by telephone. At the time of the inspection, the service provided care and support for 10 older people living in their own homes.

The service has 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 provider did not have robust systems in place to ensure that people were safe. The recruitment process was poor and the provider did not carry out the required checks before an offer of employment was made. Risk assessments did not provide guidance for staff on how to mitigate the risks when providing care and support to people who used the service. Relevant information about safeguarding procedures was not available to people and members of staff so that they could raise safeguarding concerns to the appropriate authorities. There were unexplained gaps in medicine administration records and staff had not had a competency assessment done to ensure that they were competent in the management and administration of medicines.

Staff had not received the relevant training for the work they did. Not all staff had received regular supervision and appraisals. None of the staff had any competency test carried out to establish whether they had the required skills, and experience for the work they did.

People were positive about how their care was managed by the care staff. They were treated with kindness and compassion. People were treated with respect and their privacy and dignity was promoted.

People's care needs had not been thoroughly assessed, reviewed and delivered in a way that promoted their wellbeing. The care plans lacked detailed information and they were not person-centred. There was a complaints procedure in place.

The provider did not have effective quality monitoring processes in place to drive continuous improvements. There were no effective systems in operation to seek the views of people in a formalised way and to assess and monitor the quality of service provision.

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.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking enforcement action against the registered provider. We will report further on this when it is completed.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The recruitment procedures were poor. The required checks had not been carried out before an offer of employment had been made.

There was no clear guidance for staff on how to mitigate risks when supporting people in meeting their needs.

Information about safeguarding procedures was not available to people and staff.

People's medicines were not always managed safely. Gaps identified in medicine charts did not explain the reasons for the omissions.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the relevant training for the work they did. They had not had their competency assessed to ensure that they were competent in their roles. Not all staff had received regular supervision or appraisals.

People's consent was not sought in a formalised way before any care or support was provided and staff were not trained on the requirements of the Mental Capacity Act 2005.

People were supported to access other health and social care services when required.

Is the service caring?

Requires Improvement

The service was not always caring.

Care records did not show that people and those lawfully acting on their behalf had been involved in making decisions about their care and treatment.

Staff understood people's individual needs and provided care in

a way that respected their choices.

Staff respected people's privacy and dignity, and they supported them to maintain their independence.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have an assessment of their needs carried out and care records showed that their preferences, choices and wishes had not been taken account of when delivering care.

People's care plans had not been reviewed.

The provider had a complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have a quality assurance system in place for assessing, monitoring and improving the quality and safety of the service. They also did not seek the views of people and those acting on their behalf, staff and other stakeholders so that they continuously evaluated the service and to drive improvement.

There were no quality audits carried out to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who used the service.

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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.

This inspection took place on 7, 12, 20 July and 3 August 2016 and was announced. The provider was given 48 hours' notice before our first day of inspection because we needed to ensure that somebody would be available at their registered office. The first three inspections were carried out by one inspector who also made phone calls to people using the service, their relatives and staff on the 14 July and 2 August 2016. The inspection on 3 August 2016 was carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report. We reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with three people who used the service, four relatives, four members of staff and the registered manager. We looked at five care plans during the inspections in July 2016 and six new care plans on 3 August 2016 including risk assessments, guidelines, healthcare information and records relating to medicines. We looked at 11staff files including recruitment information and training. We checked how the provider handled complaints and, assessed and monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

The provider did not have a robust recruitment policy and procedure in place. The system used to recruit members of staff was poor. On 12 July 2016, we looked at six staff files and noted that five of the six staff had only one reference obtained. We noted that the staff file which contained two written references had one dated December 2012 when the member of staff had started work in January 2014. We saw from the Disclosure and Barring Service (DBS) checks carried out that one member of staff had an offence recorded which was current at the time of their employment. We spoke with the registered manager about this and he said, "I like to give people a chance. They had done their time." This information had not been explored further nor had a risk assessment been carried out to ensure that people were not at risk. The application forms for all six members of staff had not been fully completed. For example for one member of staff, the contact details and addresses of both referees had not been completed.

During the inspection on 3 August 2016, we looked at 11 staff recruitment files. We noted that two members of staff did not have a DBS check carried out prior to them starting work. The recruitment file for another member of staff showed that their DBS had been completed in April 2016 when the member of staff was working for another company. Six of the 11 staff files had significant unexplained gaps in their employment history. For example, the recruitment file showed that an application form had been completed on 20 October 2014. The member of staff had attended college from 1980-1985. However, the employment history section in the application form stated 'N/A'. For another member of staff, their application form stated that they were born in the 1950's. However the application form completed had an employment history from June 2015. Nine of the 11 staff's recruitment files had only one reference obtained. One member of staff did not have any references on file. For the member of staff who had two references, we noted both had been hand written and neither contained any company logo or identification to confirm their authenticity. There were no records to evidence that written references had been followed up to check their validity.

We saw that one member of staff had a residence permit which stated that they were on Points- Based-Immigration System (PBS) Dependent. There was no information regarding any eligibility to work in the United Kingdom. We discussed it with the registered manager if they had explored whether the member of staff was eligible to work, they told us that they had not. This meant that people were at risk of receiving care and treatment from staff who might not be suitable or legally able to work. We also found in the recruitment file for another member of staff that the photograph was different to their passport photograph. In addition, the copy of the passport photograph had a number of lines on it which indicated that it was a photo of a different person. We showed it to the provider's consultant who was present for the whole of the inspection and they were also not convinced that the two photographs were for the same member of staff. The provider had failed to ensure that all relevant checks had been carried out prior to an offer of employment being made. Gaps in employment history had not been explored; two written references had not been obtained as stated in their recruitment policy; the eligibility of staff to work in the United Kingdom had not been explored. Therefore, the provider was putting people at risk of receiving care and treatment from staff who may not be suitable. They had not taken appropriate steps to ensure that people were protected from the risk of avoidable harm.

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

The provider did not have a procedure in place to raise safeguarding alerts to the relevant authorities. The staff we spoke with were not able to fully demonstrate that they understood how to recognise signs of potential risks of harm and raise safeguarding alerts. When we spoke with the registered manager about their understanding of the safeguarding procedure, he told us that he had completed the safeguarding training when he had worked for the National Health Service, but was unable to explain current procedures and guidance. This meant that the registered manager had not kept up to date with the local safeguarding procedure.

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

During the inspection on 12 July 2016, we noted that four of the five care records we looked at did not have any risk assessments. There were no clear instructions for staff on how to support people to ensure that they were not at risk of harm or injury. We noted from one person's care records that care staff needed to prompt them to take their medicines to maintain their mental wellbeing. There was no assessment of the person's mental health needs nor was there a mental health risk assessment. The registered manager said, "The person has 'dark thoughts' and staff are there to provide a companion and to make sure that they take their medicines."

On 3 August 2016, we looked at the care plans for the six people who used the service. Although the care plans had identified individual risk, there was no guidance for staff in all of them on how the risk should be mitigated. There were no records for all six people to evidence how they were supported in understanding the risks and how they would be prevented from receiving unsafe care and treatment. We noted from the care records of one person that they had been identified as having difficulty in swallowing and at risk of choking. We found that they did not have a Speech and Language Therapist (SALT) assessment carried out nor had a referral been made. There was no information for staff on how to support the person to minimise the risk. We prompted the registered manager to raise this with the person's GP. The following day, the registered manager informed us that they and the GP were monitoring the person and that they did not require an assessment from the SALT team. There were no environmental risk assessments completed where care staff supported people in their homes. For example, there were no risk assessments undertaken to establish whether the bathrooms were suitable for the use of a hoist or wheelchair, or the kitchens had safe appliances for staff to prepare meals. This exposed people and the care staff to hazards.

The provider was failing to provide the relevant information to staff so that they would be able to support people appropriately in managing the risks and to meet their needs safely.

The provider had a policy and procedure for the administration of medicines which referred mainly to the code of practice for Nursing and Midwifery Council for registered nurses. The policy did not state whether the safeguarding team, the Commission and other relevant agencies should be notified when there had been medicine errors or other incidents involving the administration of medicines. We noted from the medicine administration records (MAR) that there were gaps, with no explanation for the reasons for these omissions. There was no record to show that staff had been trained to administer medicines and their competency checked. Therefore, the provider was failing to ensure that people were not at risk of unsafe treatment.

These failings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The service did not have a formalised duty rota system in place. During the inspection on 3 August 2016, the registered manager showed us on how staff were allocated to support people, but there were gaps in the allocation for three people as their care rotas had not been fully completed. The registered manager told us that they allocated the same members of staff to the same people, as the majority of staff were 'live-in carers'. The registered manager said that they provided support to people when members of staff were on leave or unwell. There was no management structure in place to support staff in an event of an emergency. The registered manager said that when they were on leave, they kept their mobile phones on and that they were in the process of recruiting a registered nurse to provide cover on an ad hoc basis.

People we spoke with said that they felt safe. One person said, "Yes, I do feel safe. I am in my own home and there is a carer I can call out. If I did not feel safe, I would call my daughter who deals with everything for me." Another person said, "I feel safe. I have no concerns."

People said that they were happy with the consistency of the staff. One person said, "I get the same carer for three weeks and another for one week when the other one returns." Another person said, "I have the same carer during the week and another one at weekends. The manager also covers when the carer is on holidays."

There was no system in place to monitor and record incidents or accidents. The registered manager had recently obtained an incident and accident book; he told us that he would record any incidents and accidents from now on. The staff we spoke with told us that they would call for an ambulance in an emergency if required by a person using the service and that they would inform people's relatives and the registered manager.

Inadequate

Is the service effective?

Our findings

There was an absence of training for staff to ensure they were able to carry out their job role. None of the six members of staff whose records we looked at had completed a formal induction programme when they started working at the service. During the inspection on 12 July 2016, we found that up to date training had not been provided and the provider relied on training that staff had completed in other employment rather than providing the training staff required. This meant the provider could not assess if staff were competent to carry out their role and this placed people at risk of harm from inappropriate care.

The registered manager said that they had given access to the staff to complete the training on line but we found little evidence to support this was used. One member of staff said, "I have done some training with another care provider, but no training here as yet." The registered manager showed us copies of the training one member of staff had completed previously with other providers. The lack of completed care plans and risk assessments, which are key basic nursing and care documents to support the safe delivery of care, were not in place. There was no evidence to show what training the registered manager had undertaken in order to ensure he was meeting the requirements of the Nursing and Midwifery Council (NMC) code of conduct and fitness to practice. His revalidation of the NMC registration was up for renewal in October 2016 but the registered manager had not taken steps to identify how he was going to meet the requirements to retain his nursing registration.

There were no processes in place to ensure that care staff received regular formal supervision and appraisals. Not all staff had received supervision or appraisals to assess their competence and provided developmental opportunities. We saw five out of 11 members of staff had received their supervision for the first time following our visit on 20 July 2016 and one member of staff had their appraisal. We spoke with four members of staff who told us that they did not receive regular formal supervision. The provider was failing to ensure that staff employed to care and support people in meeting their needs were qualified, skilled, competent and experienced. This exposed people to the risk of unsafe care.

Staff had not received training in Mental Capacity Act 2005 and therefore they were not aware of the requirements of the Act. The members of staff we spoke with told us that they had not completed the training. One member of staff said, "I am going to do it on line today." This meant that the provider had failed to ensure that staff had received the required training so that people would be supported appropriately in making decisions about their care and treatment.

These failings were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were not able to make decisions for themselves did not have a mental capacity assessment carried out this meant that they were not protected by the safeguards put in place under the Mental Capacity Act 2005. 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. At least one person had a power of attorney in place but there were no records of this, what it applied to; health and welfare or finances or both. This meant that where safeguards were in place to protect people's rights the provider had not explored this or made information available to staff to ensure those rights were protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff always talked to them before carrying out any task. One person said, "My carer is very good. She gets me up, assists me with my shower and helps me to get dressed. We talk to each other all the time." Another person said, "The carers know what to do. They always ask me when I am ready for their assistance." Staff understood their roles and responsibilities in ensuring that they sought people's verbal consent before providing care and support. One member of staff said, "Because I am a live-in carer, I know their daily routines but I still ask them when they are ready for their personal care."

Staff confirmed that they supported people with their meals and that they ensured that they had enough to eat and drink. One person said, "I am able to make sandwiches for myself, so I don't go without." Another person said, "Carers do the cooking on a limited basis, but I do have enough to eat and drink. I get a cup of tea in the morning and we have our breakfast together every morning."

People told us that they were supported to access other health services, such as GPs, community nurses, and hospital appointments by their relatives so that they received the care necessary for them to maintain their health and wellbeing. They told us that the care staff would make an appointment if they required some medical attention. One person said, "My daughter makes all the appointments for me. She has the 'Power of Attorney' and my health care needs are met."

Requires Improvement

Is the service caring?

Our findings

Although people felt that they were well cared for, the service was unable to demonstrate how they cared for people who lived with dementia, people who had difficulties in swallowing and those with mental health needs. This meant that people were at risk of receiving inappropriate care and treatment.

People told us that staff provided care and support in a compassionate way. One person said, "The carers are very caring, kind and considerate. They live in the other room and they come to help me during the night when I call. They are good." Another person said, "I have had my live-in carer since June last year. She gives me my breakfast and medicines. I have no concerns."

People told us that they were involved in making decisions about their care and support they received. One person said, "When the manager came to see me the first time, I told him how I would like my support from them. We discussed it and they help me the way I want. They are very good." Another person said, "When I was discharged from hospital, the manager came to see me and I have a carer seven days a week. They are very helpful. They give careful attention when changing the catheter bags." However, none of the care records we looked at showed any evidence that people or their relatives had been involved in the decisions about their care.

People told us that staff treated them with respect, and maintained their dignity. One person said, "The carer respects my privacy and dignity and I respect hers too." Another person said, "Yes they do respect my privacy and dignity, they shut the door and cover me up when I am in the bathroom." Members of staff we spoke with demonstrated that they understood the importance of respecting people's dignity, privacy and independence by ensuring that they promoted people's human rights. One member of staff described how they ensured that people's privacy and dignity was respected. They said, "When assisting with personal care I shut the door, close the curtains, assist her on the commode. When giving a bath or a shower, I cover the top and then the bottom half." Another member of staff said, "Because I am there in the house with them, we plan the day and I support them in how they wish to spend the day."

Staff were able to tell us how they maintained confidentiality by not discussing about people's care outside of work or with agencies not directly involved in their care. One member of staff said, "We don't talk about people to anybody else except for people who are involved in their care." We noted that information pertaining to people had been held securely within the provider's office and the registered manager informed us that the information they retained within their electronic devices were protected. However, the provider did not always kept information relating to people securely as they had previously loss a diary from their vehicle following a theft which contained information about people's appointments and other activities.

Inadequate

Is the service responsive?

Our findings

People did not have a person centred care plan in place. We looked at the care records of five people who used the service. All the five care records did not have an assessment of needs carried out prior to them using the service. None of the five care records had a care plan in place to show how people were supported in meeting their needs. Neither did they show that people's care needs had been reviewed so that staff had up to date information. There was no evidence that people's preferences, choices and wishes have been taken into account when planning their care. The care plans did not demonstrate that people's views about their care needs had been taken into account to ensure that staff supported them appropriately in meeting their needs.

We found the care plans did not fully identify people's needs. For example, in one person's care plan it stated the person was able to take their own medicines from a dossette box, but required prompting and observing to ensure that they took their medicines appropriately. The care plan did not provide staff with any information on how to prompt the person to ensure they took the medicines or how they should respond if the person did not take their medicines. For another person, the care plan stated that they required laxatives to prevent constipation. There was no information to tell staff when the laxatives should be given. Similarly for urinary incontinence, the care plan simply stated that the person wore pads and pants. There was no detail as to how frequently these should be checked. The registered manager told us that he understood that the care plans needed to be far more detailed and give sufficient information for care staff to know what to do. We noted that none of the care plans had been reviewed to show that any changes in the person's care needs had been reflected, and appropriate care and support provided. This meant that staff were not provided with clear guidance on how to support people in meeting their needs. There was no information as to how staff would deliver care to meet people's cultural, spiritual or diversity needs as these were not identified within the care planning process.

People we spoke with told us that they had a care folder in their home and that staff recorded what they did on a daily basis. One person said, "I see the carer writes in it, but I do not look at it. The manager comes and talks to us in a general way." The staff we spoke with said, "I write in the folder what I have done every day. We talk about people with the manager, but we do not have a review. He does spot checks." However, the care plans we looked at did not evidence that people had been involved in the planning, management and review of their care and treatment.

These failings were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were advised of the complaints system by way of the' Service User Guide' and the 'Statement of Purpose'. Section16 of the provider's 'Service User Guide' suggested that in the first instance the complaint should be made to the member of staff directly and only if it was not resolved satisfactorily, should it then be escalated to the 'Duty Manager' or manager by telephoning the office. It went on to say that the manager would make every effort to resolve the issue and would contact the complainant within 48 hours and give a full written response within 28 working days. It also advised that people could contact CQC to make a

complaint. The Statement of Purpose contained a fuller, although slightly different, version of the process. However neither document referred people to the local authority or the Ombudsman.

A document to record complaints had been devised to replace the notebook that had previously been used, although this was empty as the service had not received any complaints. People we spoke with said that they did not have any concerns or complaints about the service. One person said, "I will speak to the manager or my daughter and they will sort it out. I don't have any reasons to make a complaint."

Inadequate

Is the service well-led?

Our findings

On our first visit on 7 July 2016, the registered manager was unable to provide us with records that supported the running of the service as the computer was broken. There was no access to or details of the individuals receiving a service from the agency. The whole system for managing the day to day activity of care delivery was reliant on the information stored in the registered manager's mobile phone. We returned by agreement to view information on the 12 July 2016 and found that there was still limited information with regard to care records and care delivery available, we took urgent enforcement action following this visit and referred one matter as a safeguarding alert to the local safeguarding team. On the 3 August 2016 we again visited the service to view documentation and systems used to operate the agency. On this visit we again found that the provider and registered manager had not taken the necessary steps to address the shortfalls.

The provider did not have a system in place for assessing, monitoring and improving the quality and safety of the service. There were no records to evidence that the provider had sought the views of people who used the service and those acting on their behalf, staff and other stakeholders so that they continuously seek to evaluate the service and drive improvement.

There was no evidence of any staff meetings or opportunities for staff to contribute to the improvement of the service by having a forum for sharing ideas. Support for staff was ad hoc and reactive as opposed to a system in place to inform and guide staff. There were no staff duty rotas in place to ensure that people's care and treatment from staff was covered in advance. There was no management structure in place when the registered manager was on leave. The provider told us that they were in the process of recruiting a qualified nurse to provide cover and support for staff when they were not available.

The provider did not have a clear focus on the visions and values of the company and how these would be implemented. We found no evidence to support that staff had any knowledge of the values of the business or how they we expected to provide a service built upon those values.

They did not have an audit system in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who used the service or staff. For example, where a risk had been identified, such as choking, there was clear guidance for staff on how to mitigate the risks which meant that people were exposed to the risk of receiving unsafe care.

The registered manager had obtained a 'Quality Assurance Standard Audit Tool' in anticipation of the inspection on 3 August 2016 and they told us that they did not have time to complete an audit. On examination we found that the 'tool' related to a service provided by a physiotherapist and was not appropriate for use by a care provider. The registered manager said that they would explore a suitable audit tool.

There was no system in place to ensure that information about incidents and accidents was shared with members of staff to prevent recurrence. Recruitment practices did not protect people from staff who may be

unsuitable to work with them. There were no care plans to support the delivery of safe care and the staff were not trained to deliver care to people they were allocated to care for in their own home for 24 hours per day. There was no emergency cover should staff be unable to contact the registered manager. We looked at six care plans and none of them contained any evidence to indicate how people or those lawfully acting on their behalf consented to the care they received.

This exposed people and staff to the risk of harm, as there was no system operating or effective to ensure that the registered provider was operating within expected standards of governance and having robust oversight of the service.

These were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have an up to date 'Statement of Purpose'. The current statement of purpose simply consisted of four paragraphs on the experience of the registered manager and eight paragraphs on the complaints procedure. There was no information about the type of services being provided and for whom. This meant that people who used the service were not provided with information about the service, their contractual obligations and rights and whether the service was the right one for them in meeting their needs.

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

The service has a registered manager. People we spoke with told us that the manager was approachable and helpful. One person said, "I know the manager because he takes me to see my husband who lives in a care home." One relative said, "The manager is doing a good job." Staff confirmed that the registered manager was supportive and that they could contact them at any time of the day.