

Companion Care Agency Limited

Companion Care Agency

Inspection report

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Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

Inadequate



Is the service well-led?

Inadequate



Summary of findings

Overall summary

About the service

Companion Care Agency is a domiciliary care agency providing the regulated activity of personal care to people in their own homes. The service provides support to people with physical and cognitive support needs. At the time of our inspection there were four people using the service.

People's experience of using this service and what we found

There was no robust system or process in place to safeguard people from abuse. There was no evidence care staff had received the necessary training and knowledge required to recognise or respond to signs of abuse. There was a significant lack of effective risk assessing and safety management systems and processes in place. This meant the provider failed to be proactive in protecting people's safety. There was no evidence the provider had considered peoples' ability to make their own choices and consent to care, therefore we could not be assured the provider was compliant with the Mental Capacity Act (MCA).

There was a lack of medicine recording systems in place, and the provider failed to demonstrate staff were adequately trained and competent to administer medicines safely. Individualised care plans were in place for people requiring support with their medicines, however, these were not effective. Due to a lack of monitoring and record-keeping, opportunities to learn lessons and improve quality of care were missed.

Staff had access to personal protective equipment (PPE) in people's homes. The provider was unable to demonstrate they were making safe recruitment decisions, as there was no evidence pre-employment checks were being completed, including Disclosure and Barring Service (DBS) checks.

There was a lack of opportunity for staff to raise concerns or make suggestions and there was no oversight of staff training. There was a lack of robust systems and processes in place to ensure quality of care. There was no registered manager in place, and there was a lack of oversight from the provider. Therefore, the provider could not be assured the service was well led. The registered provider was unclear of their legal regulatory responsibilities and there was some confusion over the organisational role of the nominated individual.

Staff and relatives of people using the service told us, if people had issues or concerns, the provider would respond and address them. There was some indication the provider was engaging with health and social care professionals to ensure that people's needs were correctly assessed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

This service was registered with us on 10 October 2020 and this is the first inspection.

Why we inspected

The inspection was the first at this service. We initially commenced a fully comprehensive inspection looking at all five key questions (Safe, Effective, Caring, Responsive and Well-Led). Due to a lack of engagement and information from the provider, we narrowed the scope of our inspection to a focussed inspection, looking only at two key questions (Safe and Well-led). This meant we were unable to provide the service with an overall rating for this inspection.

Enforcement and Recommendations

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

We have identified breaches in relation to the safe care and treatment of people; the safe recruitment of fit and proper persons; and how the service was led, including oversight of care, at this inspection.

During the inspection, the provider submitted an application to deregister the service and cease all regulated care activities. This decision impacts our regulatory response to this inspection and enforcement action taken.

Follow up

The overall rating for this service is 'Inadequate' and the service should therefore be in 'special measures'. This means we would typically keep the service under review and, if we do not propose to cancel the provider's registration, we would re-inspect within 6 months to check for significant improvements. However, as this service has now deregistered, this process is not required. We will continue to monitor the situation with the closure of this service and reconsider our regulatory powers should changes in circumstances occur.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-Led findings below.

Companion Care Agency

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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Inspection team

The inspection was completed by one inspector.

Service and service type

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

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. The provider informed us during the inspection that the registered manager had left the service the month prior. However, the provider was required to notify us before the registered manager had left the service and failed to do so.

Notice of inspection

We gave a short period notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 7 April 2022 and ended on 22 April 2022. We visited the registered office location on 7 April 2022, and a second unregistered office location on 14 April 2022.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received from the public and other health and social professionals. We sought feedback from the local authority although none was received. We used all this information to plan our inspection.

During the inspection

We met with the director of Companion Care Ltd at the registered location, however, they informed us they no longer operated from this location and all records and documentation had been transported to a new office. We met with the nominated individual at the new office location, however, there were no records or documentation available for us to review. We made multiple requests for documentation to be sent to us electronically, however, most requests went unfulfilled. We did receive some care records for three people and organisational policy and procedures. The director and the nominated individual did not know where documentation was being stored.

We interviewed the provider, nominated individual and two care staff as part of the inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also received feedback from one family member. We sought feedback from the local authority and external professionals, however, no feedback was received. We made multiple requests to the provider for contact details of people using the service, but none were received. We were therefore unable to obtain any feedback from people using the service.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- We asked the provider what systems and processes were in place to safeguard people from abuse. The provider told us there was an electronic system in place to record safeguarding concerns. We made multiple requests for this documentation, but no evidence was produced. The provider failed to demonstrate people were safeguarded from abuse.
- We made numerous requests to the provider for evidence of care staff safeguarding training. No records were produced. We were therefore not assured care staff had received the necessary training and knowledge required to safeguard people from abuse.
- A safeguarding policy was in place; however, this referred to a different organisation and did not reflect the systems and processes described by the provider during the inspection. The absence of an effective safeguarding policy tailored to the service meant there was no clear system or process in place to ensure people were safeguarded from abuse.
- Staff told us they would report safeguarding concerns to the provider. However, due to the absence of effective safeguarding systems and processes, we remained unassured people were kept safe from harm.

Assessing risk, safety monitoring and management

- We made multiple requests to the provider for evidence to support their ability to assess risk and monitor safety. The provider failed to produce any meaningful evidence. There was a significant lack of robust risk assessing and safety management systems and processes in place. This meant the provider failed to be proactive in protecting people's safety.
- The provider failed to protect people from potential falls risks. People using the service required support from staff to transfer and mobilise with the use of equipment. A review of the limited care records provided, indicated the provider had failed to fully assess the associated risks with such care activities and ensure people's safety. Poor quality risk foresight increased the risk of potential falls.

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 MCA 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.

When people receive care and treatment in their own homes, an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

- There was a lack of evidence available to enable a comprehensive assessment of the providers compliance with the Mental Capacity Act 2005. No specific concerns were identified as part of inspection, and no concerns were raised by relatives or staff. However, due to the absence of evidence, we could not be assured the provider was compliant with the MCA.

Using medicines safely

- The provider failed to demonstrate that staff were adequately trained and competent to administer medicines safely. We made numerous requests to the provider for evidence of training records and competency assessments, however, no records were produced. This meant people were at risk of receiving medicines from untrained staff.
- Staff told us they were supporting people with their medicines, but were unable to confirm if they had received regular training and competency checks to ensure they were doing so safely.
- There was a lack of evidence produced to indicate medicine administrations were being safely recorded and monitored. We made multiple requests to the provider for medication administration records, but no legible records were produced. A lack of robust medicine recording, and monitoring systems resulted in poor and unsafe medication management. This meant people were at potential risk of not receiving their medicines as prescribed
- Individualised care plans were in place for people requiring support with their medicines, however, these were not robust. Medication care plans lacked detail regarding people's individual needs, their required daily medicines and reasons for prescription. This meant staff lacked guidance regarding people's individualised use of medicines and preferred medication routines.

Preventing and controlling infection

- We made multiple requests to the provider for care staff training records, however, no records were produced. The provider failed to demonstrate they had ensured staff were adequately trained in infection prevention and control. This meant staff were potentially not mitigating potential risk of infection due to a lack of guidance and training.
- The provider told us staff had access to personal protective equipment (PPE) in people's homes. We spoke with care staff as part of our inspection who told us they were wearing PPE such as face masks, apron, gloves and shoe covers.

Learning lessons when things go wrong

- There was a significant lack of monitoring and record-keeping. This meant the provider was unable to evaluate quality of care and drive improvement. This resulted in missed opportunity to learn lessons and improve quality of care.

Medicines were not managed safely, and risk was not adequately assessed or monitored. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- We asked the provider to produce evidence of staff DBS checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The provider was unable to

produce any records or information to indicate they were completing these checks. This meant the provider was unable to make safe recruitment decisions.

- The provider was unable to produce any evidence to indicate they were completing background reference checks for care staff. This meant the provider was not assured people were suitable for their roles.
- There was no evidence to indicate the provider was completing identification checks for care staff. This meant the provider could not be assured staff were who they presented themselves to be and had a legal right to work within the United Kingdom.
- The provider failed to produce any evidence that care staff employment histories had been discussed and reviewed at point of employment. This is a CQC requirement of providers delivering a regulated activity. This meant the provider could not be assured staff had the necessary experience or skill set to fulfil their role.

Staff were not recruited safely. This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was a lack of opportunity for staff to raise concerns or make suggestions. We made multiple requests to the provider for documentation regarding team meetings and staff supervisions; no records were produced. A lack of opportunity for staff to raise concerns or communicate with the provider is a warning sign of a closed culture. We define a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm.
- Staff told us if they needed to speak with the provider, they were able to contact them on the telephone. However, there was no evidence the provider was proactive in seeking engagement with staff to monitor performance, seek feedback or promote a positive inclusive culture.
- There was no oversight of staff training. We made multiple requests to the provider for information in relation to staff training, however, no documentation was produced. A lack of training oversight meant staff were not provided with opportunities to promote good outcomes for people.
- The provider was unaware of their legal responsibilities in relation to duty of candour, however, we identified no specific areas for concern during the inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was a lack of effective systems and processes in place to ensure quality of care. For example, there was no medication auditing process in place to ensure people received their medicines correctly and as prescribed. Care plan evaluations were carried out, but these were not effective as they did not identify weaknesses or missing information within care plans. For example, a lack of detail regarding people's mobility requirements. A lack of robust quality assurance systems meant the provider failed to monitor and improve quality of care.
- There was a quality assurance policy in place, however, this was not being followed. For example, the policy outlined regular managerial quality checks, but there was no evidence these were being completed. Failing to follow policy resulted in missed opportunities to improve the quality of the service.
- There was a lack of oversight from the provider. Prior to our inspection there had been a registered

manager in place. The registered manager left the service in March 2022. The provider told us the registered manager was responsible for quality of care, however, there was no evidence to indicate the provider had effective oversight of the service. Therefore, the provider could not be assured the service was well led.

- The registered provider was unclear of their legal regulatory responsibilities. For example, the provider had failed to notify us regarding the departure of the registered manager. The inspector raised this with the provider during the inspection, but the provider failed to respond, and no notification was submitted.
- There was some confusion over the organisational role of the nominated individual. The provider told us the nominated individual contributed toward care assessments and other activities. The nominated individual told us they were involved with the service solely in an advisory capacity. Confusion over roles and responsibilities contributed towards the service not being well led.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were no service user or staff surveys in place to gain feedback and enable analysis. A lack of feedback channels resulted in missed opportunities to gain feedback and improve quality of care.
- Staff and one relative of people using the service told us, if people had issues or concerns, the provider would respond and address them. However, there was no documented evidence to suggest the provider was monitoring complaints or feedback effectively.
- Care staff and one relative of a person using the service, told us they were able to contact the provider if needed. However, there was no evidence the provider was proactive at seeking feedback or input.

Poor quality oversight and a lack of quality assurance systems was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider told us they considered peoples' equality characteristics in relation to their communication needs, and scheduled translators to attend meetings or assessment where required.

Working in partnership with others

- There was some indication the provider was engaging with health and social care professionals to ensure that people's needs were correctly assessed. For example, the provider had facilitated an occupational therapy assessment to inform care practices.