# Precious Care Services Ltd

# 11a Station Road

## Inspection report

11a Station Road
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17 November 2016

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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

11a Station Road provides domestic services and personal care to older people; people with learning disabilities or autistic spectrum; physical disabilities; people living with dementia and people who misuse drugs and alcohol. The service was providing a regulated activity to 13 people who were using the service at the time of our visit.

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 and associated Regulations about how the service is run.

During our visit we became aware people may be at risk of harm. We found a number of unsafe care practices that placed people at risk of harm. The registered manager failed to report an allegation of suspected abuse. We found there was no procedure in place to mitigate the impact. There were no risk management plans in place for people who had identified risks; where people had unexplainable injuries the service did not take appropriate action; some staff did not undertake safeguarding refresher training and new staff did not receive the relevant training at all. The provider carried out unsafe recruitment practices. This meant people were at risk of abuse, harm and inappropriate care.

People and their relatives said they felt safe. They told us staff arrived on time and the care received was not rushed.

Staff did not receive appropriate induction, supervision and training. Staff had no understanding of the Mental Capacity Act 2005 (MCA) and how it related to their work practice, as they had not undertaken the relevant training. The MCA protects people who lack capacity to make specific decisions and gives statutory principles what should be applied in order to support them. The service did not act in accordance with the requirements of the MCA. We have made a
recommendation for the service to seek guidance on undertaking mental capacity assessments based upon the MCA.

People's nutritional needs were not always met. Where people had medical conditions that affected their nutrition care records did not show how staff should support them. This meant people's nutritional needs were not effectively being met.

'Baseline initial assessment of needs' which contained information such as people's care and support needs, medical histories, family and social histories and preferences, were either partially completed or not evident in personal care records. This had the potential of people receiving care and support they did not want. There were no arrangements in place to ensure people's individual care needs were regularly reviewed and kept up to date. This meant the service did not ensure the care and support delivered to people was still relevant. We have made a recommendation for the service to seek guidance on how to

record outcomes of complaints received.

People felt the service was responsive to their needs.

The registered manager demonstrated a lack of understanding of fundamental standards and their regulatory responsibilities. They failed to notify us of safeguarding incidents that had occurred in line with the required regulation and submit information requested by us within a set timeframe. There were no effective systems and processes in place to assess and monitor the quality of the services provided. This meant people's welfare and safety was placed at risk because the service was not effectively managed.

People felt staff were caring, treated them with respect and in a dignified manner. Staff had developed good working relationships with people and understood their needs. The service promoted and encouraged people to be independent.

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, they 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 a set 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 a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and will report on this when it is completed.

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

## 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.

We found a number of unsafe care practices. These centred on a lack of evidence to show how people who had identifiable risks were managed; the lack of action taken when unexplained injuries occurred; unsafe recruitment practices and lack of safeguarding training for staff. This meant people were at risk of abuse, harm and inappropriate care.

People and their relatives said they felt safe with staff. They told us staff always arrived on time and the care and support received was not rushed.

### Is the service effective?

**Requires Improvement**

The service was not effective.

Staff did not receive appropriate induction, supervision and training. This meant people received care from staff who were not effectively supported.

Where people lacked capacity to make specific decisions the service did not act in accordance with the law.

People's nutritional needs were not consistently being met because where they had medical conditions that affected their nutrition, care records did not show how staff should support them.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People felt staff were caring, treated them with respect and in a dignified manner.

Staff had developed good working relationships with people and understood their needs.

The service promoted and encouraged people to be independent.

## Is the service responsive?

**Requires Improvement**

The service was not responsive.

Initial assessment which contained information such as people's care and support needs, medical histories, family and social histories and preferences, were either partially completed or not evidenced in personal care records.. This had the potential of people receiving care and support they did not want.

There were no arrangements in place to ensure people's individual care needs were regularly reviewed and kept up to date. This meant the service did not ensure the care and support delivered to people was still relevant.

People felt the service was responsive to their needs.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The service  was managed by a registered manager who did not have an understanding of the fundamental standards and their regulatory responsibilities. They failed to notify us of safeguarding incidents that had occurred, in line with the required regulation and did not respond to our request for information within the set deadline. There were no effective systems and processes in place to assess and monitor the quality of the services provided. This meant people's welfare and safety was placed at risk because the service was not effectively managed.

People provided positive feedback about the service and felt the happy with the quality of care and support received.

# 11a Station Road

**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 checked 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 was an announced inspection which was carried out by an inspector and took place on 14, 15 and 17 November 2016. The provider was given 48 hours' that the inspection was going to take place. We gave them notice to ensure there would be senior management available at the service's office to assist us in accessing information we required during the inspection.

Before our inspection we asked the provider to complete a provider information return (PIR) form. 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. The provider failed to respond to our request within the specified time. We reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

After our inspection we received feedback from an officer from the Local Authority.

During our visit, we spoke with one person, a relative, two care workers and the registered manager. We reviewed four care records, four staff records and records relating to the management of the service.

Inadequate

# Is the service safe?

## Our findings

People said they had no concerns about abuse and felt safe with staff. One person commented, "I feel very safe." When discussing the care provided to two of their family members a relative commented, "They (family members) are safe. I don't have any concerns."

The registered manager did not understand their roles and responsibilities to respond to concerns about abuse when care and support had been provided to people. They were not able to demonstrate a good understanding of the service's safeguarding policy and procedure in response to suspicions and allegations of abuse and told us they had last attended the relevant training in 2014. We found evidence that showed the registered manager failed to report an allegation of abuse. We saw no procedures was put in place to safeguard the alleged victim which meant there was a potential for the same incident to re-occur. This meant people were not kept safe from avoidable harm and abuse.

Systems and processes were not operated effectively to prevent people from being abused. The registered manager told us staff had, "Received refresher training in regards to safeguarding vulnerable adults last year." This was not supported by our discussions with staff who told us they could not remember when they had last attended the relevant training. However, staff were able to demonstrate an understanding of what they should do if they suspected abuse had occurred. This included checking for any injuries or bruises when carrying out personal care and reporting any concerns immediately to the registered manager. We reviewed staff records and found no evidence to confirm safeguarding adults training (as part of induction; essential or refresher training) had been undertaken during staff members' employment with the service.

We noted the service's safeguarding policy was last updated in June 2012. This meant people were not protected because staff were not kept to date about national and local safeguarding arrangements. After our visit we made a safeguarding referral to the local safeguarding team and other relevant agencies.

We reviewed completed body maps. These were used by staff to record any observable body injuries that may appear on a person's body. We noted no actions were taken when injuries were found and the appropriate agency was not notified. This meant people were not kept safe from avoidable harm and abuse.

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

Risks of abuse to people were not minimised because the service did not have robust recruitment procedures in place. Disclosure and Barring Service (DBS) checks that ensured staff were suitable to provide care and support to people, were not available for some staff members during the inspection visit. Confirmation of these checks was sent to us by the provider following our inspection. Written references were not sought; job applications were not fully completed; employment histories were not consistently obtained and medical questionnaires were not considered part of the recruitment process. This meant people were potentially at risk of receiving care from staff who were not of good character.

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

Risk management plans were not in place to promote people's safety. Care plans showed people had identifiable risks. There was no evidence of how these risks were being managed by staff. This meant risks to people's welfare and safety were not minimised or mitigated.

People's medicines were administered in a timely manner. A relative told us care workers ensured their family members received their medicines on time. This was supported by a staff member who explained the procedure they had carried out when administering medicines. We noted care records instructed staff on how to support people with their medicines. We found this to be in line with what the staff member had said. We noted medicine administration records (MAR) were completed and signed by the relevant staff members. However, out of the four staff records reviewed we found only one staff member had undertaken a competency assessment to carry out this task. We saw no evidence of medicine training (whether refresher or formal training) in the three remaining staff records. We noted staff members administered medicines as part of their job roles. This placed people at risk of harm because not all staff had received appropriate training on the proper and safe management of medicines.

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

People and relatives told us the right number of staff attended calls. One person went on to say staff always arrived on time and did not rush when they carried out care. This was further supported by a relative who commented, "They (staff) don't rush and remain for the agreed time and will stay even longer if need be." We found sufficient staff was available to meet people's care and support needs.

Requires Improvement

# Is the service effective?

## Our findings

People received care and support from staff who were not appropriately inducted, trained and supervised. A staff member told us as part of their induction they had to shadow staff for three days. We noted the staff member had no previous experience of working in the care industry before they started working for the service. There was no record to show the staff member had undertaken formal induction and whether they had been signed off as competent to carry out their job role. The registered manager informed us they had not been able to review staff training needs or arrange refresher training and acknowledged this was something that needed to be addressed. We found some staff had received training but this related to training that was undertaken from their previous employment. Whilst other staff had received no training since joining the service. Comments from staff included, "I have had no formal training" and "I have had training but I don't know if it needs refreshing." This meant people received care from staff that were not appropriately trained to effectively carry out their job roles.

Staff felt they received appropriate support and stated they were able to speak with the registered manager as and when needed. We noted supervision meetings (one to one meetings) were undertaken but this only appeared to take place when there were areas of concern to discuss. The registered manager told us spot checks, which involved unannounced visits to observe staff practice, was used as part of supervision. However, this was only undertaken when concerns had been raised. There were no structured meetings to allow staff to discuss amongst others, their personal development needs and no evidence of end of year appraisals to review staff's overall performance. This meant staff were not effectively supported.

This was a breach Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. Domiciliary care services must apply to the Court of Protection for legal authorisation to deprive a person of their liberty.

Staff had not undertaken the relevant training and were not able to explain how they should apply the MCA to their work practice. Where people lacked capacity to make specific decisions we found no evidence of mental capacity assessments being undertaken. Care records contained consent agreements that covered areas such as support with medicines but these were not signed by people who or those who represented them. This meant there was a possibility that where people lacked capacity to make specific decisions they would receive unlawful care as the service did not act in accordance with the legislation.

We recommended the service seek guidance on undertaking mental capacity assessments, in line with the principles of the Mental Capacity Act.

People's nutritional needs were not always met. A 'meeting nutritional needs' assessment was carried out on a person who had a medical condition. We noted the assessment did not state the level of risk to the person but indicated various objectives and advised staff to contact the GP if required. There was no record

of how the person's medical condition affected the person's nutritional needs and how the person should to be supported. This was noted in another personal care record which meant people's nutritional needs were not always effectively being met, as the service did not follow nationally recognised guidance when carrying out nutritional assessments.

This was a breach Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they offered people choice and would ensure people had balanced meals. This was supported by care records which showed people's food preferences and dietary needs. For instance, we noted one person preferred not to have sugar in their tea but preferred to have sugar in their cereal. It was clearly noted for staff to offer them balanced meals such as fruit with their breakfast. Staff said if they identified people were losing weight or had a change in appetite; this would be immediately reported to the office.

People were supported to maintain good health and had access to healthcare services. A staff member told us they would accompany people to medical appointments. Whilst a relative commented, "I will always get emails if they (the service) have any concerns about my parent's health. For example, high sugar levels, they (the service) will advise us to contact the GP." This was further supported by the registered manager who commented, "We encourage next of kin to contact GPs or we would make referrals to social services who would allocate social workers to people. This meant people could be confident their health needs and preferences would be met when they had to receive care and support from health professionals.

Requires Improvement

# Is the service caring?

## Our findings

During our visit we became aware people may be at risk of harm. Although the comments from people we received from people and their relatives showed they felt the staff were caring. The evidence in other sections of the report suggests that the way that the service was operating put people at risk and this needs to be improved before we can say that the service was caring.

People received support from staff who cared. A person said it was the attitude of staff that made them believe they cared and commented that staff were, "Very patient with me." Whilst a relative commented, " They (staff) engage in a positive and affectionate way. You can tell they're caring rather than just coming to do a job and leave." This was supported by our conversations with staff, who spoke affectionately about the people they provided care and support to.

The relative gave another example that described the caring nature of staff. They said staff had offered to collect one of their family members who was being discharged from hospital. The relative commented, "I thought this was amazing" as this was not part of staff's job role and this had helped them out of a difficult situation.

Staff had established good working relationships with the people they supported and demonstrated a good understanding of their care needs. One staff member commented, "You have to build up trust with people." The staff member was able to tell us about a person they provided care to and described their care needs, their likes and preferences. Our discussions with the person's relative and review of care records confirmed what the staff member had said.

People were able to express their views and were actively involved in making decisions. A relative commented, "My mum will say what she wants." The registered manager stated that meetings would be arranged with people and their family members to discuss any concerns or changes in care. This was supported by the relative we spoke with. We noted care records also gave staff clear instructions on how to ensure they involved people and encouraged them to take part in any care tasks being undertaken.

The service promoted and encouraged people to be independent. A staff member commented, "I would allow people to do what they can for themselves. For example, if people are putting on their clothes I will leave the room and return when they need me." We noted care records documented what people were able to do independently and the areas they required further support.

People said they were treated with respect. A relative commented, "They (staff) address my parents in a respectful way". This was supported by staff. We heard comments such as, "I never shout at them (people). I listen to what they have to say and show empathy" and "I sit down and talk with (name of person they provided care and support to), we have a good working relationship. This was further confirmed by the person who commented, "They (name of staff) are very respectful." Staff said they ensured doors were closed and people were covered when they carried out personal care. This ensured people were respected and their dignity preserved.

Staff maintained people's right to confidentiality. We viewed confidentiality agreements signed by staff to confirm they would not disclose confidential information except for the purpose of providing care and support to people. A staff member commented, "I don't allow other carers to talk about other people when I am at a client's house." We saw people's confidential personal information was kept securely in the office. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We saw evidence of the ICO registration by checking the regulator's website.

Requires Improvement

# Is the service responsive?

## Our findings

People and their relatives said they were able to contribute to the assessment and planning of their care. A relative explained, "I telephoned (service's name) and a week later they carried out an assessment. They asked questions about what my parents liked and what they used to do before they fell ill."

We found 'Baseline assessment of needs' which contained information about people's care and support needs, medical histories, family and social histories and preferences, were either partially completed or not evident in personal care records. We asked the registered manager how they were able to develop care plans without using information obtained from initial assessments. The registered manager stated they remembered what was discussed and agreed with people before people's care packages could start. The registered manager stated they were behind in writing up 'baseline initial assessments' and acknowledged our concerns. This meant there a potential for people to receive care and support that did not reflect what they said they wanted.

Care plans were personalised and outlined in detail the care and support people required at each call. One person commented, "I get the care I want." However, arrangements were not in place to ensure people's individual care needs were regularly reviewed and kept up to date. This meant the service did not ensure the care and support delivered to people was still relevant.

This was a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records documented where there were changes to people's care needs appropriate referrals were made. We noted one person had a decrease in their mobility. A referral was made to the appropriate health professional. We saw action was taken to ensure the person received the required support. After our visit we received information from a local authority officer who stated people said the service was responsive to their needs and in particular, the registered manager responded to them in a prompt manner.

People were supported to follow their interests and take part in social activities. The service arranged 'social care visits' these involved taking people out to places of interest or other places they wanted to go. A relative spoke positively about the impact these visits had on their family member, who had previously been restricted in their home due to mobility problems. The relative commented, "Once a week staff will come and take X (family member) out shopping to the high street. They will also take X (family member) to other places. This has really made a difference to them just being sat in a room watching TV all day." Care records captured people's social interests and preference but we noted this was not consistently evidenced in all care records reviewed.

People told us they would talk to staff if they had any concerns. The service had a complaints procedure in place. The registered manager stated a copy of it was placed in people's care records in their homes. This was supported by the people we spoke with and in people's personal care records kept in the office. Staff knew how to respond to any concerns people raised. A system was in place to log, investigate and respond

to complaints. We noted the majority of the complaints had been responded to and investigated within the appropriate timescale but we saw no evidence to show if these had been resolved to people's satisfaction.

We recommended the service seek current guidance on recording outcomes of complaints received.

Inadequate

# Is the service well-led?

## Our findings

People felt the service was well-led. We heard comments such as, "From my experience I think it's well managed" and "It's a very good company." Staff agreed with this but mentioned what they thought could be improved. Comments included, "The service provides good care. Most of our clients are old and we really do go all the way out to look after them" and "I can't complain. I enjoy my work. I have good relationships with the manager and other staff. I would love to have some formal training."

CQC registration requirements, including the submission of notifications and any other legal obligations were not being met. During our visit we found the registered manager failed to notify us of safeguarding incidents that had occurred, in line with the required regulation.

This was a breach Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered manager demonstrated a lack of understanding of the fundamental standards and their regulatory responsibilities. This was because they took on a 'hands on' approach by providing care and support to people rather than carrying out their responsibility of managing the service. They commented, "I mainly work with new clients and then when they have settled I introduce them to their carer." As a result of this we found the service did not operate effective systems and processes to ensure their compliance.

We found the provider was unable to identify where quality and or safety were being compromised and was unable to respond appropriately and without delay. For instance, when safeguarding concerns had been brought to their attention.

There were no comprehensive audits undertaken to monitor the quality and safety of the services provided except in one area, care records. However, the care plan audits were not effective as they did not identify any of the concerns we had found during this visit.

The service had no systems to enable them to identify and assess risks to people's health, safety and welfare and management of the service. For instance, there was no evidence of risk assessments; baseline initial assessments; signed consent to care agreements; reviews of care; discrepancies in the service's recruitment processes and lack of staff training; supervision and personal development. We found information in regards to people's personal care were not up to date or non-existent. Communication sheets which recorded how care and support was delivered to people were illegible due to the low standard of recording. We brought this to the attention of the manager who acknowledged that some staff members were not able to read or write. The registered manager informed us they had spoken to the staff members in question but they were not able to present us with any evidence to support this or show us what further action they had taken to support staff. This placed people at risk of receiving unsafe care because records pertaining to people and management of the service were not accurate, complete, legible and contemporaneous.

Prior to our inspection we had asked the provider to complete a Provider Information Return form (PIR). This contained information about the operation of the service. The registered manager confirmed they had

received this but could not give a good reason why it was not submitted within the deadline. Therefore, the PIR could not be used to inform our judgements in this inspection.

We found policies and procedures were not kept up to date in line with nationally recognised guidance.

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

The service sought the views of people. We reviewed five completed 'quality monitoring questionnaire'. People were happy with the care provided and positive comments was made about regular care workers always arriving on time; people being advised of any changes with their care workers; people felt staff were adequately trained;  were given written information about the care provided and they were made aware of how to make complaints. Complementary comments from the questionnaires included, "I am satisfied with everyone that comes so far" and "Good, communicate well, really friendly people." This was supported by feedback given to a local authority officer. People said they were happy with the quality of the service provided.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The service failed to notify CQC of certain events when it was legally required to do so. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The service did not ensure people's preferences were always recorded and reviewed. This could have led to people not receiving a personalised service. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The service did not ensure where required people's nutritional needs were met. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The service did not ensure robust recruitment processes were in place to ensure staff were of a good character to work with people who used the service. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing |

The service did not ensure systems were in place to sufficiently support staff in their role.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The service did not always ensure staff received training in the safe administration of medicines. Risk posed to people had not always been assessed and reduced. |

**The enforcement action we took:**

We issued a warning notice.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The service did not ensure appropriate systems were in place to protect people from abuse. |

**The enforcement action we took:**

We issued a warning notice.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The service did not ensure policies and procedures were updated in line with national guidance. There was ineffective record management system in place to ensure people's safety. |

**The enforcement action we took:**

We imposed a condition on the provider's registration.