Mrs Jane Marie Somai

Caterham Domiciliary Care Agency

Inspection report

18 Raglan Precinct
Townend
Caterham
Surrey
CR3 5UG

Tel: 01883334748
Website: www.cdcauk.com

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service:
Caterham Domiciliary Care Agency provides personal care and support to people living in their own homes. This includes three people in supported living accommodation owned by the provider. Services are provided to older people, those with a mental health diagnosis, physical and learning disabilities and sensory impairment. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At this inspection we focused on the people that lived in the property owned by the provider who were in receipt of the regulated activity 'personal care'.

People's experience of using this service:
People were not being protected from the risk of abuse. There had been instances of abuse from staff where the provider and registered manager had doubts about their suitability to work in the supported living home. Risk assessments were not always detailed around the needs of people with a mental illness or those that had a behaviour that challenged. Incident forms were not being completed in relation to incidents of behaviours. There were other risk assessments present that gave guidance to staff for example on moving and handling and people's skin integrity.

The recruitment of staff was not robust and training and supervision for staff was not always effective in ensuring good care. The registered manager was not following good practice in relation to infection control particularly around COVID 19. Consent was not always being obtained from people where necessary and where people lacked capacity the principles of Mental Capacity Act 2005 were not being followed.

Pre-admission assessments did not always take place and care plans did not always contain accurate information about people. The leadership at the service was not robust and appropriate quality assurance was not taking place.

Rating at last inspection:
The last rating for this service was requires improvement (published 8 April 2019) and there were multiple breaches of regulation. At that inspection we identified breaches in relation to the lack of choices around the care provision, the lack of detailed care planning, the quality and safety of people's care, training and supervision of staff, the principles of the Mental Capacity Act not being followed, and the lack of quality assurance undertaken at the service.

Why we inspected:
We undertook a targeted inspection due to concerns we received relating to incidents of alleged abuse and to review the progress made by the service to become compliant with the multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report only covers findings in relation to care which people received, safe care and treatment, safeguarding people from abuse, consent to care, staffing and quality assurance. The overall rating for the service has not changed following this targeted

inspection and remains Requires Improvement.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement:
We have identified continued breaches in relation to the safety of care provided and the quality assurance of the service.

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

Follow up:
We will continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner. We will continue to work with the local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Inspected but not rated. Details are in our Safe findings below.	**Inspected but not rated**
Is the service effective? Inspected but not rated. Details are in our Effective findings below.	**Inspected but not rated**
Is the service well-led? Inspected but not rated. Details are in our Well-Led findings below.	**Inspected but not rated**

Caterham Domiciliary Care Agency

Detailed findings

Background to this inspection

The inspection:
This was a targeted inspection to check a specific concern relating to people not being safeguarded from abuse and about the safe care and treatment people were receiving.

Inspection team:
Our inspection was completed by two inspectors.

Service and service type:
Caterham Domiciliary Care Agency provides personal care and support to people living in their own homes and to 13 people living in two properties owned by the provider. The inspection was only focused on one of the supported living accommodations and did not look at the other supported living home or the care for people who lived in private accommodation. Services are provided to older people, people with mental health issues, physical and learning disabilities and sensory impairment.

The service had a manager registered with the Care Quality Commission. 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. The registered manager was present on the day of the inspection.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because the registered manager is normally only present in the office in the afternoons. We needed to be sure that they would be in.

We visited the office location on 19 June 2020 to meet with the provider and the registered manager; and to review care records and policies and procedures. With permission, we visited three people in the supported living home to observe care.

What we did:
Our inspection was informed by information we already held about the service including notifications that the service sent us. We checked records held by Companies House.

We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We received feedback from the local authority which informed our planning and judgements.

We spoke with two people who used the service. We spoke with the provider, the registered manager and three members of staff. We reviewed three people's care records. We requested policies and information to people's tenancies.

We requested additional evidence to be sent to us after our inspection that related to two recruitment files for staff, staff supervisions, pre admission assessments and staff contact details. Part of this information was received and used as part of our inspection.

After the inspection we spoke with one relative and a representative for another person.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

We will assess all of the key questions at the next comprehensive inspection of the service.

The purpose of this inspection was to follow up on concerns that related to people being safeguarded from abuse. We also reviewed the progress the service was making to become compliant with the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified in relation to the management of risks associated with people's care.

Systems and processes to safeguard people from the risk of abuse

- One person told us they felt safe with staff. They told us they recently had concerns with staff who used to work at the service but that, "I'm comfortable with all other staff now." One relative told us they had not had any concerns with how their loved one was treated by staff.
- Despite this, people were not always protected from the risk of abuse as the provider and registered manager had not taken appropriate action to ensure people were safeguarded.
- The provider and registered manager told us they had previous concerns about a staff member who was no longer employed at the service. The provider told us, "That's why we went in so often." When asked why they had not directly addressed the concerns they said, "We could have done stuff. As a company there was too much trust and we did not get any feedback that anything was wrong."
- There had been a recent incident at the supported living home where people reported they had been abused by staff members. Although the incident was witnessed by another staff member, this was not reported until a person spoke to another member of staff. This meant people were left vulnerable to abuse during this time.
- A person told us they had recently been hit in their face with a cushion by another person using the service. The person told us, "It's the second time (person) has done that to me. I told (member of staff). She didn't do anything." This was not recorded or reported to the registered manager or to the Local Authority and no actions had been taken to investigate this or to put in place measures to safeguard the person.
- Where staff had received training in safeguarding procedures, they were not always putting their knowledge of the processes into practice. As stated, we identified that one member of staff had been made aware of instances of abuse but had not reported this appropriately. Another member of staff told us when asked what they would do if they observed a person abusing another person, "They would need to be reprimanded." They were not clear about how the concerns should be escalated and reported.
- At the previous inspection we highlighted more detailed information was needed in the safeguarding policy around the local authority that needed to be contacted in the event of an alleged incident. At this inspection we found this information was still not present on the policy. This meant that staff may not always know how they could raise concerns with the local authority.

As people were not always being protected from the risk of abuse this is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection

At our last inspection of the service the provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Care plans did not accurately demonstrate the risks to people and how risks should be mitigated. This was particularly in relation to behaviours which challenge, and risks associated with people's mental health diagnosis. For example, one person's risk assessment made mention of the risks around a person's behaviours. The guidance stated that staff were to distract the person but there was no guidance on what might trigger this behaviour and strategies to avoid this.
● Staff told us one person frequently had behaviours that challenged. However, they were not recording this behaviour or related incidents to analyse any trends or triggers to these behaviours. There was no evidence to show that the registered manager had sought support from external professionals regarding this. Their care plan stated their behaviours impacted on other people living in the home and the strategy stated was to take the person to their room.
● People were left at risk of COVID 19 virus as the registered manager had not adhered to infection control processes. The provider had implemented practices during COVID 19 to ensure that staff were washing and disinfecting their hands when entering people's homes. However, we observed the registered manager entering the home we were inspecting without washing their hands or using anti-bacterial gel.
● The staff bathroom we were asked to use did not have paper towels for staff to dry their hands. Instead there was just a cloth hand towel for all staff to use increasing the risk of spread of infection. This was also raised as a concern by the local authority who had recently visited the service.

As risks were not always being managed in a safe way this is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were aspects to the risks around care that were managed appropriately. These included risk assessments that related to moving and handling, skin integrity and people's food intolerances.
● During the inspection we observed staff wearing gloves and masks when appropriate to do so and in line with infection control guidance.

Staffing and recruitment

● People were at risk as the provider had not ensured all new staff were thoroughly checked to ensure they were suitable to work for the service. The provider's policy stated that they required two references for staff before they started work. Of the two staff files we reviewed both only had one reference. For one member of staff there was no reference from their most recent employer.
● Sections of the applications forms staff filled in were not fully completed. For example, there were gaps in both staff education histories and there was no evidence to show the provider had sought clarification on this.
● In one of the recruitment files it was noted the provider had made attempts to obtain a DBS check for the member of staff. There was a note on the file that the member of staff has been asked to bring the returned

DBS certification to the office so this could be checked. However, there was no evidence that this had been done. This mean they were not able to determine whether the member of staff had any past convictions that needed to be considered before they started the role.

● The provider's PIR stated, "We have a rigorous recruitment policy. We do not employ newcomers until satisfactory references have been received." However, we found this was not the case. This was of particular concern given recent safeguarding and conduct concerns raised about staff who were employed.

As robust recruitment procedures were not in place this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service effective?

Our findings

We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to look at a specific concern we had about the lack of training and supervision and whether the principles of the Mental Capacity Act (2005) were being followed.

We will assess all of the key question at the next comprehensive inspection of the service.

Ensuring consent to care and treatment in line with law and guidance

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. We checked whether the service was working within the principles of the MCA.

At the last inspection we found that the provider was not following the principles of MCA and consent was not always obtained before care was delivered. There had not been enough progress made to demonstrate compliance at this inspection.

- Although forms were completed that related to consent to care assessments of capacity were not consistent where specific decisions needed to be made. Decisions were being made for people without appropriate steps being taken to assess their capacity to make these decisions for themselves. For example, in one person's care plan it stated their wardrobe in their bedroom needed to be kept locked. It stated this was because the person liked to pull the clothes out. There was no capacity assessment that related to this or evidence of any best interest discussion to determine that this was the least restrictive option available to them.
- The provider had recently installed CCTV into the home in all communal areas. However, no steps had been taken to gain consent from people in relation to this. Where people had capacity, they were asked by the provider to read and sign a document to say they understood that CCTV had been installed rather than people agreeing and consenting to it. The registered manager told us, "It was my decision to put CCTV up."
- Where people lacked capacity there had been no capacity assessment specific to installing CCTV or evidence of any best interest discussion to determine that this was the least restrictive option.
- One person had a deputyship in place to manage their finances. However, the provider had requested the deputy to sign to agree to all aspects of care despite them not having the authority to do so. The provider had not ensured the person had an independent advocate in place to support them with decisions around their care despite their MCA policy stating, "People should also be provided with an independent advocate, who will support them to make decisions."

● Although staff had received MCA training, they lacked understanding of the principles. We spoke to staff members who were unable to demonstrate understanding of how people should be supported to make decisions and were not familiar with the process around best interest decisions. The provider confirmed after the inspection that they will be providing staff with additional training around MCA.

As the requirement of MCA and consent to care and treatment was not followed this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection we identified that sufficient training and supervision had not been provided to staff. At this inspection we found there were still shortfalls around this.

● Training provided to staff was not effective in ensuring they understood what was being delivered. The provider told us when staff joined the service, they were required to undertake mandatory training over a period of three days in addition to completing the care certificate over a period several weeks. The provider advised they did not do an assessment after the three days to determine what staff had understood to ensure staff were competent to undertake their role. They said they would talk to staff to see what understanding they had of the training. However, on the day of the inspection staff knowledge of mental health conditions was not good.
● One member of staff had returned to the service after six months. However, they had not been provided with any updated training or competency checks since returning. The registered manager told us, "We didn't do that (induction training) with (member of staff) this time as they just took him straight on as they knew he was capable of doing what he does." However, they did not provide evidence to us of how they determined this. A member of staff told us, "I think staff need more refresher training."
● Although there were supervisions taking place, this was not effective in ensuring that any shortfalls identified were followed up. For example, where concerns had been raised with staff regarding their conduct there were no formal processes in place to review their practices at work There had been no recorded supervisions taken with the member of staff despite the provider telling us, "Some stuff they (staff member) said they were doing, they weren't doing."
● We asked the registered manager how they ensured staff working in the supported living home were competent. They told us, "I am in there (the supported living house) a lot, observing, they (people) know they can talk to me. I know that their care is being delivered to a certain level. I'm not saying we're doing it all perfectly. We can only do what we can do." There was no record of the observations they undertook to demonstrate how they were effectively monitoring staff competency and conduct.

The lack of effective training and competency checks is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At the last inspection we found care and treatment was not planned to meet people's individual and most current needs. At this inspection we continued to find concerns around this.

● We asked the provider to send us the pre-admission assessments they undertook for the three people that received a regulated activity in the home. However, they only provided one completed assessment for one person. We saw a copy of a letter from a mental health trust that provided some detail about the background of a person. However, there was information in this letter that was not used to develop their

care plan.

● Care was not always considered for people living with a mental illness. We asked the registered manager to tell us about the therapeutic care being provided to those people living with a mental health diagnosis. They told us, "A lot of talking, sitting down talking, making sure they're okay. See what they want to do, go out, all those sorts of things." However, we found there was a lack of understanding of standards of care for those people living with a mental illness in order to proactively support people to have good mental health outcomes.

● The local authority fed back to us that people at the home needed to be more, "Nurtured" and there was a lack of stimulation. The provider's website stated in relation to people in the supported living homes, "We focus on individual based outcomes to allow individuals to grow and develop. Outcomes can focus on things like, personal dignity, having choice and control over decision making, health and wellbeing, quality lifestyles, feeling valued and making a positive contribution, education and employment, social and leisure." We found this was not taking place in practice.

As there was a lack of detailed assessments of people's needs before they delivered care and standards of care were not suitably provided to people living with a mental illness this is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

Is the service well-led?

Our findings

We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to check a specific concern we had about the management of the service and the quality assurances processes. We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At the last inspection the systems and processes to review the quality of care were not established and operated effectively. At this inspection we found the provider had not made sufficient improvements.

- Staff told us they felt supported by the management team. One told us, "They are brilliant. The management here are amazing, they make sure staff and service users are their priority." Another told us, "The managers are available when you call." We requested the contact details of other staff that worked in the home to gain their feedback. However, this was not provided within the timescales discussed with the registered manager.
- Despite this positive feedback from staff we found there was a lack of robust leadership at the service. We identified incidents of where shortfalls in the conduct of staff had been identified. However, there was insufficient action taken by the provider and registered manager to monitor this in order to keep people safe. They had taken disciplinary action in relation to the conduct of two members of staff. However, people had been left in the care of the staff despite the provider and registered manager having reservations about this. The provider told us there had been missed opportunities to act sooner.
- Although policies were in place these were not always being followed by the registered manager or staff. For example, the accident policy stated, "A written record should be kept of any accident, incident or near miss, however minor, which occurs." We found that this was not taking place. No record had been made of the person alleging a safeguarding incident and there was no formal recording of incidents of behaviour of another person. Therefore, there was no clear mechanism for reviewing and analysing incidents in order to respond to safety concerns or identify patterns that required additional support.
- Records were not always accurately maintained. Information in care plans were not always accurate and did not always reflect the most up to date needs of people. In one care plan it stated the person communicated with Makaton (a form of sign language) however the provider told us, "(Person) doesn't do Makaton. (Person) does about two words." Another care plan gave details of a person's previous employment however the information was incorrect. The PIR stated, "We also re-assess at every review to ensure that the information that we have is up to date and relevant." We found this was not always taking place.
- The provider had failed to identify and address shortfalls in record keeping. People's daily notes lacked person centred information how they people felt throughout the day and what conversation topics were spoken about. This information can help provide responsive and personalised care to a person.

● The provider and registered manager had not considered the needs of people living at the service when new people moved in. For example, one person moved in to the home this year that did not require personal care to be delivered. There had been no assessment of their needs to determine whether they would be suitable to live with other people that lived there. The registered manager told us when asked what they knew of the person's background, "Not very much. I assessed (person) as a vulnerable person who needed care. We only get to find those things out as we get to know (person)."
● During the inspection we raised with the registered manager and provider their website listed the wrong person as the registered manager. We asked them if they would correct this. This had still not been addressed at the time this report was written.
● There is a history of breaches of regulation and lack of action by the provider to improve the care. At the inspection on 27 February 2019 we identified breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The action plan provided to us after the last inspection stated they had taken action to meet the breaches of regulation including. "We have introduced more robust supervisions to ensure that staff are following procedures." We found they had not met their action plan.
● The provider did not have effective systems in place to monitor the quality of care or drive improvement. The provider and registered manager had not taken responsibility to ensure that the appropriate work was being carried out.
● Although there were some systems to assess the quality of the service provided, we found these were not always effective. These systems had not ensured people were protected against some key risks described in this report about people being safeguarded from abuse and unsafe care and support. We found problems in relation to lack of effective staff training and supervisions, care planning, infection control and lack adherence to MCA. This had not been proactively identified or addressed through the provider's quality assurance processes.

As systems and processes were not established and operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that there were detailed assessments of people's needs before they delivered care and standards of care were not suitably provided to people living with a mental illness

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that the requirements of MCA and consent to care and treatment were followed

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that risks were always being managed in a safe way

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that people were always being protected from the risk of abuse.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were established and operated effectively.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that robust recruitment procedures were in place.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff had effective training and competency checks.