Ms Thelma Jean Greensill

1st Class Care

Inspection report

276 Coalway Road
Merry Hill
Wolverhampton
West Midlands
WV3 7NP

Date of inspection visit:
05 March 2019
06 March 2019
12 March 2019

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service: 1st Class Care is a domiciliary care service which is registered to provide personal care to people living in their own homes and in a supported living environment. At the time of inspection, five people were receiving care and support services.

People's experience of using this service:
• The quality of care people received had significantly deteriorated since the last inspection.
• Poor risk assessment and management meant people had been placed at risk of avoidable harm.
• Staffing levels were not sufficient to support people to lead full and active lives.
• The provider had failed to escalate incidents or allegations of concern to relevant third parties.
• Some people had experienced harm because of poor practice and ineffective governance systems and processes.
• The service met the characteristics of inadequate in Safe, Well-Led and Caring.
• Please see more information in Detailed Findings below.

Rating at last inspection: The service was last inspected in April 2017 and was rated as Good.

Why we inspected: This inspection was brought forward in response to concerns received about the quality of care people received. We received concerns about a number of key care aspects, including staffing levels and people's safety. At the time of the inspection we were aware of incidents being investigated by third parties.

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

Follow up: The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

Following the inspection we referred our concerns to the local authority responsible for safeguarding. We also requested information from third parties to enable us to decide what regulatory action we should take to ensure people's safety.

Shortly after the inspection the provider submitted an application to cancel their registration with us and advised they planned to close the service from May 2019.

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

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 effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring finding below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

1st Class Care

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by concerns received about the safety of people using the service. These allegations are subject to a third party investigation and as a result this inspection did not examine the circumstances of the allegations.

However, the information shared with CQC about the service indicated potential concerns about the management of safeguarding concerns.

Inspection team:
Two inspectors conducted the inspection.

Service and service type: 1st Class Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to adults who have learning disabilities. The service also provides care and support to people living in three 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Notice of inspection:
We gave the service 18 hours' notice of the inspection visit because it is small and the provider is often out of the office supporting staff or providing care. We needed to be sure that they would be in.
Inspection site visit activity started on 5 March 2019 and ended on 6 March 2019. We visited the office location on 5 and 6 March 2019 to see the provider and office staff; and to review care records and policies and procedures. Following the site visit telephone calls were made to relatives and staff on 12 March 2019.

What we did:
Prior to the inspection we reviewed notifications we had received from the service. A notification is information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with one relative, two staff members and the provider. We looked at three people's care records, records of accidents, incidents and complaints and quality assurance records. We also looked at four staff recruitment records.

Following the inspection we requested further information from the provider. Most of this was received, however some information, for example the provider's safeguarding and voluntary workers policies were not received at the time of writing the report.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of abuse and improper treatment. The provider had not recognised safeguarding concerns and as a result, concerns for people's safety had not been identified, reported or investigated by relevant external agencies.
- Where people raised concerns about their treatment staff members had not considered the allegations as potential safeguarding concerns. Some allegations and incidents were recorded but the provider failed to escalate the matters to appropriate external agencies and in doing so left people exposed to the risk of harm or abuse. During the first day of the inspection we referred our concerns about the provider's processes to the local authority responsible for safeguarding.
- Staff told us they had been instructed by the provider to report any concerns to them. During the inspection visit the provider informed us of an incident where an injury had been caused to a person. The provider told us they had carried out their own investigation into this incident and therefore it had not been referred to the local authority safeguarding team.
- The failure to take action when they are alerted to suspected, alleged or actual abuse or the risk of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risk assessments relating to people's health, safety and welfare did not always reflect people's current needs and risks. This exposed people to the risk of receiving unsafe care.
- One person required support to manage seizures related to epilepsy. The risk assessment related to 'Epileptic Fit' had last been reviewed in October 2018. The person had experienced seizures in January 2019 but this had not been reflected in the risk assessment guidance for staff; nor had consideration been given for how staff should manage the risk when the person was not at home.
- Healthcare records for two people showed both service users were monitored by staff in relation to their blood pressure. The provider told us they had decided to implement these checks, without first seeking guidance from a health care professional. There was no risk assessment relating to the monitoring of these or guidance for staff on how to respond to high or low readings and when medical advice may need to be sought. This exposed service users to the risk of harm.
- The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staffing arrangements did not reflect people's assessed needs. For example, two people who each

required one to one support for 12 hours per day did not receive this for the four-week period prior to the inspection visit.

● Staff rotas showed that on eighteen days between 9 February and 1 March 2019 only one member of care staff was on duty where there should have been a minimum of two.

● The provider's failure to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's care and treatment needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment processes were not safe. The provider had failed to protect people from the risk of receiving care from unsuitable staff. Recruitment records for two staff members showed no employment checks had been conducted to assess their suitability for the role. Furthermore, Disclosure and Barring Service (DBS) checks that had been applied for had not yet been received. The DBS service allows providers to check people's suitability to work with vulnerable people. There was no risk assessment in place to detail how the provider intended to manage the staff members and protect people from the risk of receiving care from staff who had not been safely recruited.

● The provider's failure to ensure recruitment procedures were established and operated effectively was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● We were unable to review medicines management systems during the inspection visit as the medicines records were kept at people's home address. Following the inspection, the provider sent us medicines administration records for two people. These records reflected that people had received their medicines as prescribed. However, one person's medicine records contained additional hand writ en instructions and it was not clear whether a healthcare professional had agreed these instructions.

● We asked to see records relating to the auditing of medicines records but the provider told us they were not available.

● Staff told us and records confirmed they had received training in medicines administration. However, the provider told us they had not carried out competency assessments to ensure staff were safe to administer medicines.

● Staff demonstrated a good understanding of people's medicines and their possible side effects.

Preventing and controlling infection

● Staff had received training in infection control and told us they had access to Personal Protective Equipment (PPE) as required.

● There were no infection control audits in place.

Learning lessons when things go wrong

● The provider had a system to record accidents and incidents. However, no analysis of accidents and incidents had taken place, so themes and patterns had not been identified or monitored. The provider told us they conducted investigations following incidents; however these were not recorded to ensure lessons were learnt. This meant the risk of harm or incidents reoccurring were not being reduced.

● For example, we saw that one person had experienced a number of falls. The provider told us the person had been referred to an appropriate healthcare professional. However, no investigation of these incidents had taken place and measures had not been implemented to reduce the likelihood of this happening again.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

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.
- People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. For example, people were only able to participate in leisure activities when the provider arranged sufficient staffing and there were restrictions placed around food and snacks. This meant people could not choose what or when to eat and were frequently not able to take part in activities they enjoyed because staff were not available.
- Systems developed by the provider supported and encouraged restrictive practices which meant people's choices and decisions were, at times, dependent on the instructions given by the provider and the availability of staff. For example, care plans gave staff specific instructions on the portion size of meals and number of snacks a person could be offered. They also instructed staff to check people's clothing or jewellery, regardless of the person's individual preferences.
- The provider told us they had installed CCTV in to the communal areas of one of the properties where people lived. We asked how people who may lack capacity to understand the purpose of this had been consulted. The provider told us, "People were told it was being installed. As far as I know people understood."
- The use of control or restraint that are not necessary to prevent a risk of harm was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Where people did not have the capacity to make some decisions about their care and support we found they had been supported by advocacy services to ensure decisions were made in their best interests.

Staff support: induction, training, skills and experience

- People did not always receive support from staff who had the appropriate skills, knowledge and experience to meet their needs. Not all staff had up to date training in relevant areas of knowledge.
- For example, one person had a condition of epilepsy; staff providing care to this person had not received training related to epilepsy and how this might affect service users living with this condition. This placed service users at risk of receiving unsafe or inappropriate care.
- One staff member, who worked alone at night, had not undertaken recent training in fire safety. This exposed people to the risk of avoidable harm.

Supporting people to eat and drink enough to maintain a balanced diet

● Prior to the inspection we received information of concern about people's access to suitable amounts of food. We found that instead of people being supported to plan meals and purchase their own food, the provider was purchasing food for people as a group; which restricted people's choices.

● Healthcare records showed the provider had given guidance to staff about restricting one person's portion sizes, without first seeking the advice of a healthcare professional. The provider told us they used government guidelines on body mass index to work out how much each person should weigh. They then restricted portion sizes if the person's weight increased above the suggested range. This took place without consultation with the person or a relevant healthcare professional.

● The provider's failure to deliver care that meets people needs and reflects their preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Relatives told us that staff helped people to access healthcare services and monitored their health needs. One relative told us how well staff had managed recent incidents when their family member had experienced ill health. They said, "[Staff member's name] even responded in the middle of the night. [Person's name] was taken ill at 2am and they came straight over."

● Care records showed people were supported to access relevant healthcare professionals and services when required. We saw the provider had made prompt referrals where people's health needs had changed.

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

● People's needs were assessed prior to moving into the service and records showed that care plans were reviewed regularly. However, although they contained information about people's preferred choices, these were not always reflected in the care and support people received from staff.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence
- We found that language used by the provider did not promote people's dignity. The provider told us that people's behaviours were 'not normal' and that they felt their role was to 'teach people' the right way.
- The provider spoke about people with compassion; however they led the service in the use of institutional practices which placed unnecessary restrictions on people. For example, people's care plans contained specific restrictions on their daily living choices, such as choices of snacks and biscuits.

Ensuring people are well treated and supported; respecting equality and diversity
- Relatives we spoke with told us they felt staff were considerate and caring.
- However, we identified areas of practice which were not consistently caring. The provider had not ensured people were adequately supported in terms of protecting their safety and ensuring people were supported by sufficient numbers of well trained staff. These concerns are covered elsewhere in the report.

Supporting people to express their views and be involved in making decisions about their care
- Care records reflected that people had, at times, been supported to express their views about their care. For example, two of the care records we reviewed had been signed by the person.
- However, the restrictions placed on people's lives by insufficient staffing levels meant people did not always have the opportunity to make decisions about their care. For example, people's right to choose when and where they took part in leisure opportunities was restricted by staffing decisions.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- The provider had failed to design care or treatment with a view to achieving people's preferences. Where preferences could not be met, staff had not explored alternatives to support people to make informed choices.
- People had not always been involved in making decisions about their care and support and as a result they were placed at risk of receiving unsafe care that did not reflect their individual needs.
- During the inspection we found institutionalised care practices that did not reflect people's personal preferences. For example, people were transported on a daily basis to spend time at the provider's other services, as staff were not available to support them in their own homes.
- The provider's failure to provide opportunities for relevant persons to manage the service user's care or treatment was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Care plans were regularly reviewed by staff; however they did not always reflect recent incidents that had taken place.

Improving care quality in response to complaints or concerns

- People and relatives knew how to complain but not all complaints were acted on.
- We viewed minutes from resident's meetings which reflected that people had been asked how they felt about the service they received. However, where people had raised repeated concerns we found that there was no system in place to ensure people's concerns had been addressed or to understand any emerging themes or patterns of people's concerns.

End of life care and support

- People had brief end of life care plans in place which outlined their future wishes. No-one was receiving end of life care at the time of the inspection.

Inadequate

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- The provider's quality assurance processes were ineffective and did not identify the issues found during the inspection. These included concerns with recruitment, staff training, risk management, person centred care and staffing levels and details can be found earlier in this report.
- Numerous concerns were identified. These included incomplete or inaccurate risk assessments, unsafe recruitment practices, poor management of safeguarding concerns and institutionalised care practices. These concerns had the potential to negatively impact on people's health, safety and wellbeing.
- The checks carried out on people's care plans had failed to identify where records were not individual to the person or to evaluate the impact of insufficient staffing. Healthcare checks were carried out without regard for people's individual needs.
- The provider had failed to ensure that effective systems were in place to monitor the quality of care people received and to identify risk that was present within the service. Where areas of risk were known to the provider, they had failed to ensure that systems were in place to drive improvements and to ensure service users were protected from harm as far as possible.
- A failure to have effective systems and processes in place to monitor and mitigate risks to people was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- The provider failed to ensure their own skills and knowledge were up to date with best practice and guidance. The provider told us they felt their practice and knowledge was dated and they had not kept up to date with changes in legislation.
- The provider was despondent about their ability to make the required changes or improvements. They told us they no longer felt equipped to drive quality improvements or deal effectively with the actions required of them by both CQC and the local authority.
- The provider told us they were considering closing down the service as it was no longer financially viable to operate.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider failed to have effective systems in place to monitor the safety of people's care and support. We saw that care plans and risk assessments had been audited each month. However, these audits had

failed to identify concerns or changes in people's care needs. For example, they had failed to identify that one person's epilepsy risk assessment had not been updated following recent seizures.

● The provider had failed to maintain effective oversight of staff training and skills. This lack of oversight placed people at risk of harm of receiving support from staff who did not have the skills and knowledge to meet their needs.

● Person-centred care was not promoted in the service and people did not always receive high quality care. This has been demonstrated in the other findings of this report.

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

● The provider had failed to listen to or to act on feedback from people about their experiences of care.

● Where people had given feedback about their care the provider had not always responded to their concerns. 'Client' meeting minutes reflected people's feedback about not feeling they were respected by staff members. The provider had not spoken with the person or investigated the reasons for this.

Working in partnership with others

● The provider had been open with relevant external agencies about their financial situation and their lack of understanding about how the service should be operated.