Glaze Compassionate Care Limited

121 High Street

Inspection report

121 High Street
Chasetown
Burntwood
Staffordshire
WS7 3XL

Tel: 01543220866

Date of inspection visit:
29 January 2018
01 February 2018

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

Summary of findings

Overall summary

This comprehensive inspection took place on the 29 January and 1 February 2018 and was announced. This service is a domiciliary care agency. It provides personal care to people living in their own homes in and around the Burntwood area. It provides a service to adults. At the time of our inspection the provider was supporting 14 people.

Although this is the first comprehensive inspection of this location the service was previously registered at a different location where it was rated as requires improvement. The provider was in breach of their registration with us as they had not informed us of their change of address. We also found concerns with how complaints were managed and the systems in place to manage quality needed improving. The same manager was in post at this inspection and the provider remains the same.

There is no registered manager in post; however the manager is in the process of completing their registration with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection people are not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service do not support this practice. Individual risks to people were not considered or managed in a safe way and when needed action was not always taken to ensure people were safe. When incidents occurred there were no systems in place to respond to these and action was not taken to minimise the risk of reoccurrence. The systems in place to manage medicines were not always appropriate to ensure medicines were managed safely. When people had as required medicines there was no guidance in place for staff to follow to ensure people receive their medicines as prescribed.

Although people and relatives did not raise concerns about calls time, we found that people did not always receive their allocated call times. And these were not monitored by the provider. There were no systems in place to ensure staffing levels were sufficient to meet people's needs. The provider's recruitment process did not always ensure staffs suitability to work within people's homes. Staff received training and induction however the provider did not check staff knowledge following this or check the competencies of staff in areas such as the administration of medicines. Staff demonstrated an understanding of safeguarding however we could not be sure all incidents had been reported in line with these to protect people from potential harm.

There were no systems in place to assess and monitor the quality of the service so this information could not be used to drive improvements. We could not be assured that all guidance staff needed to keep people safe was available and this demonstrated a lack of leadership within the service. We could not be assured we received all notifications required and the provider understood their responsibility around registration with

us.

As guidance for staff to follow was not available people did not receive support that was individualised. People's support needs were not understood and people's cultural needs had not been considered. Information was not made available to people in a format they could always understand. There was no procedure in place for managing complaints.

People were happy with the staff that supported them. When people required support with meals they were offered a choice and people were referred to health professionals accordingly. The provider shared information with other organisations. There were infection control procedures in place and people's privacy and dignity were maintained. Staff felt listened to and supported by the manager and provider.

The overall rating for this service is Inadequate and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

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.
Individual risks to people were not considered or reviewed. When accidents or incidents occurred, there were no current systems in place so that improvements could be made and lessons learnt. The provider did not have effective systems to assure us that people received their medicines safely and as prescribed. People did not receive their allocated call times. We could be sure people were always protected from potential abuse. There were infection control procedures in place.

Is the service effective?

Requires Improvement

The service was not always effective.
Where people lacked the capacity to make certain decisions, this had not been assessed to demonstrate any decisions made were in their best interest. Staff knowledge or competencies were not assessed after training. People's care was not always delivered in line with current legislation. People who were supported with meals were offered a choice. When needed people received support from health professionals and the provider shared information with other organisations.

Is the service caring?

Requires Improvement

The service was not always caring.
People did not always receive the support they required and information and guidance about the levels of support people needed was not always available. People and relatives were happy with the staff that supported them. People's privacy and dignity was promoted.

Is the service responsive?

Inadequate

The service was not responsive.
Staff did not have the information to deliver care in an individualised way. People's cultural needs had not been considered. There was no procedure in place to manage complaints.

Is the service well-led?

Inadequate

The service was not well led.

There were no systems in place to drive improvements within the service. The provider sought feedback from people who used the service however this information was not used to make improvements where needed. We could not be assured about staffs suitability to work within the home. We could not be sure we were notified of significant events that occurred within the home. There was lack of leadership within the service.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an announced inspection. We gave the manager five days' notice of the inspection site visits. This was because the service is small and the manager is often out of the office supporting staff or providing care and we needed to be sure that they would be available. This announced inspection was carried out by one inspector and an expert by experience. The expert by experience had knowledge of care services including domiciliary services. The inspection site visit activity started on 29 January 2018 and ended on 1 February 2018.

The inspection was informed by the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service. On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we offered the provider the opportunity to share information they felt relevant with us. We used all this information to formulate our inspection plan.

At the inspection we gave the provider the opportunity to send us further information including staff rotas and information relating to care hours. We asked for this information to be provided the following day after the inspection. Although we received an email the following day stating this would be sent at the time of writing this report we have not received any additional information from the provider for us to consider.

We used a range of different methods to help us understand people's experiences. We made telephone calls to five people who used the service and two relatives. We also visited one person and their relation in their home. We spoke with two members of care staff, the manager and the provider. During the office visit we looked at the care records for six people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including audits carried out, staff rosters and safeguarding, complaints and the infection control policy. We also looked at five staff

files so we were able to review the provider's recruitment process.

Inadequate

Is the service safe?

Our findings

When incidents and accidents occurred within the service no action was taken. We were told by the manager and provider that no incidents had occurred within the service. However when we looked at people's individual care notes we saw incidents had occurred and these had not always been documented on incident and accident forms. For example, when people had fallen and when people had bruising. As there was no system in place for monitoring this information, no action had been taken. We saw documented that a serious incident had occurred in a person's home, which had potentially placed this person and their relation in a life threatening situation. Following this it was documented that, '[People's names] are safe now, no harm'. No risk assessment had been put in place and no further action considered to reduce the risk of this reoccurring. The manager and provider confirmed to us no further action had been taken. When other incident forms had been completed there was no evidence these were followed up and the manager confirmed this to us. When incidents occurred or things went wrong within the home there were no current systems in place so that improvements could be made and lessons learnt. This meant when incident or accidents occurred within people's homes action was not always taken to reduce the risk of recurrence.

Individual risks to people had not been considered. We saw that pre admission risk assessments had been completed for people identifying when they may be at risk. However, we did not see any individual risk assessments for people showing the action that had been taken and how these risks could be reduced. For example, we saw one person had fallen five weeks prior to starting using the service. They had been identified to be at risk of falling in their assessment. There was no individual risk assessment in place for this. We saw documented in the daily notes this person had fallen in December 2017 which had resulted in them attending hospital. Following this no further action had been taken. When we asked a member of staff about this person and this risk, they told us, "They had falls before but are fine now". For other people we saw when they were at risk of developing sore skin or needed fluids to keep them hydrated, there were no risk assessments in place or guidance for staff to follow. This meant staff did not have the information about individual risks to people to ensure they supported them in a safe way.

When people were supported to transfer with moving and handling equipment there were no assessments in place. The manager told us that she was trained to assess people's needs and complete these assessments however these had not been completed. There was no guidance in place identifying how people were supported and the number of staff required. There was also no system in place to check that the equipment staff were using in people's homes was safe to use.

We could not be assured the systems in place to manage medicines were safe. We saw one person was prescribed a medicine that the dosage needed to be varied following instructions from the district nurse team. We asked the manager how they ensured that staff had this information so that the correct dose was administered. They told us that they would telephone a member of care staff when they were at the person's home who would then write this on the person's calendar. There was no system in place that staff double checked this information was correct and this documentation was not stored safely at the person's home to ensure it was not changed. This meant the person was at risk of not receiving their medicine as prescribed.

When people had as required medicines, there was no guidance in place known as PRN protocols for staff to follow. This included information as to when this medicines should be administered, what it was for and how much the person could receive .Furthermore for some people we saw care staff and relatives administered medicines to people. For example, staff administered medicines for one person in a morning and their relatives did this for the remainder of the day. There was no system in place identifying what relatives had given to ensure people only received as much medicines as they could in a 24 hour period.

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

There were procedures in place and staff demonstrated an understanding of safeguarding. However when we looked at records we saw some incidents had not been reported to the local authority for investigation, as required. For example, we saw that a serious safeguarding incident had occurred and some other people had skin tears and bruising that were unexplained. There was no internal investigation into this and no follow up following the incidents that had occurred. We spoke with the manager and provider who confirmed this had not been considered as a potential safeguarding concerns. This meant we could be sure people were always protected from potential abuse. The provider had also not notified us as required of these incidents. .

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

People did not receive their assessed care hours. Although people and relatives raised no concerns records confirmed that people did not always receive the amount of time they were funded and charged for. For example for one person during the month of December 2017 we found that most of the calls they received were cut short. For three other people we looked at we found the same concerns. We spoke with the manager and provider who were unaware of this. There was no system in place to monitor call times to ensure people received the correct amount of time. The manager told us that people would send staff away early, however in these situations people's capacity had not been considered and the provider could not demonstrate that people's care had been reviewed to ensure their care needs were being safely met.

We discussed rotas and staffing hours with the manager and provider. When asked if they used a dependency tool to consider staffing levels they both did not demonstrate an understanding of this. There was no system in place to ensure there were enough staff to meet people's planned calls. We looked at a rota for one member of staff. There were no gaps between call times to ensure the staff member could travel between people's homes. Furthermore on two occasions the staff member was rostered to be in different homes at the same time. This meant the provider had not ensured that people's call times could be safely met.

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

There were infection control procedures in place and these were followed. People and staff told us there was enough personal protective equipment to use. One person said, "They always have the gloves and that when they come, it keeps them clean and reduces the risk of cross infection. They are all very good, they clean their hands before they start. Even when they do my medicines". A staff member said, "There is no issue with this it is always available. Although the provider had a policy in place there was no audit currently being completed by the provider in this area.

Requires Improvement

Is the service effective?

Our findings

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 or 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked to see if the principles of MCA were followed. When needed there were no capacity assessments or best interest decision in place for people. We saw that relatives were consenting on behalf of people without the legal power to do so. For example, one person had a consent to care form. Staff and the manager told us this person did not have capacity. We saw the person's relation had signed this on their behalf. The provider, manager and staff did not demonstrate an understanding in this area. When we asked the manager about this they told us, "I could do with refresher training". This meant the principles of MCA were not understood or followed.

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

Staff received an induction and training to fulfil their role. Although staff told us the training they received helped them support people, we could not be assured how effective the training was. For example, staff told us they had MCA training however some staff did not demonstrate to us an understanding in this area. Furthermore the provider was not checking staff competency after training had occurred to identify areas of concern or if further training was needed. For example, the provider was not checking that staff were competent to administer people's medicines safely. When we asked the manager, they confirmed this was not completed and told us, "If the staff didn't know how to do something or were struggling they would tell us". This meant we could not be sure the training staff received enabled them to support people as needed and staff had the knowledge or were competent to deliver support to people.

People's care was not delivered in line with current legislation. This was evidenced by the lack of care plans or risk assessments in place, which meant we could not determine how care was assessed and delivered to people. The provider and manager confirmed this to us.

People who were supported with eating and drinking told us staff offered them choices. One person said, "They offer me a choice". We saw that staff had recorded people's food intake when they had supported people with this.

People were responsible for managing their own healthcare needs however staff told us they would offer support to people if they requested it. For example, a staff member told us if a person was unwell they would contact their GP for them if they requested them to. Records showed us that when needed, staff had contacted health and other professionals and made referrals on people's behalf. Staff also told us they

worked alongside the district nurses. One member of staff told us, "If the district nurses are at the persons' home I would let them have any information I know about how the person has been doing and anything that may help them". This showed us that the service shared information with other organisations.

Requires Improvement

Is the service caring?

Our findings

Although people did not raise concerns with us, we could not be assured they always received the required support. Staff were not always at people's homes for the allocated times, we could not be assured people's care was not rushed. As staff often left early we did not see that they used the reminder of people's time to sit and talk with people or offer them emotional support. People were not always provided with information in a format that enabled them to understand the choices that were available for them.

People were encouraged to be independent however the levels of support people needed were not always detailed in people's records. For example, when people needed support with transferring there was no guidance in place stating what people could do for themselves. We spoke with staff who told us, "I ask them what they can and want to do, I am just there as support". A person confirmed to us they were encouraged to be independent.

People spoke positively about the staff. One person said, "I haven't had one come that doesn't treat me nicely. I have made friends with the one who comes regularly. I don't get out and often don't see anyone other than my carers, so I look forward to them coming". Another person told us, "All the carers are good, but I prefer the more mature ones". A relative commented, "They are loving and caring when they come".

People's privacy and dignity was promoted. One person said, "Very good with all that". A relative told us, "I am never in the room it's all done in private". Staff gave examples how they promoted people's privacy and dignity. One staff member said, "We would knock on people's doors and let them know we are here, if the door is open I give them a shout".

Inadequate

Is the service responsive?

Our findings

The information staff needed to deliver individualised care for people was not in place. For example, people had one care plan in place that was a breakdown of what support they received during their call. Information included, 'getting people up and washing them and putting on creams'. They were no further details provided. There was no evidence in place as to how this information was reviewed. As the information staff needed was not in place we could not be sure people received the support they required. For example, one person had a skin check chart in place. There was no information in the person's file as to why this was or what support the person needed with this. The manager told us this person was at risk of developing sore skin and their skin should be checked four times a day during each visit, and this should be recorded. When we reviewed the records we saw this had only been documented once on 18,22,23,24,25,26,28 and 31 December 2017. When we spoke with staff they told us they should check it at each visit and only record when concerns were found, however on the days that documentation was in place no concerns were reported. The manager and provider confirmed there were no systems in place to monitor this. Therefore staff did not have the information available to deliver the individual care people required.

Peoples' support needs were not understood. For example, we looked at records for one person who had a catheter in place. We saw that staff recorded the person's fluid output. No one we spoke with knew why this was completed. The total amount of output was not calculated and there was no guidance in place stating what this should be. On one occasion the person had an output of 800mls and on another occasion 2100mls, no one could confirm to us what this should be and at what point they would take action if they were concerned. The manager and provider told us this was something they had not considered. This meant we could not assured that staff had the information available to take action if they were required to do so.

People's cultural needs had not been considered. The provider had not considered people's needs in relation to the protected characteristics. The Equality Act covers the same groups that were protected by existing equality legislation, including age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. The provider confirmed this was not something they assessed or considered for people they supported. We did not see that an equality and diversity policy was in place.

The provider and manager confirmed they were unaware of accessible information standards (AIS) and were not implementing this to support people. AIS were introduced by the government in 2016 to make sure that people with a disability of sensory loss are given information in a way they can understand. We did not see any communications plans in place for people or evidence that information shared with people was available in different formats to help them make informed choices.

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

There was no procedure in place to manage complaints. The manager and provider confirmed this was an

area that needed developing. The manager and provider told us that no complaints had been made. When we reviewed an incident form we saw a person had raised concerns about a staff member. No follow up had been made and no further action taken. The manager confirmed this had not been considered as a complaint. Therefore we could not be sure the provider understood when complaints were made.

This is a breach of Regulation 16 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

At this time the provider was not supporting people with end of life care, so therefore we have not reported on this at this time.

Inadequate

Is the service well-led?

Our findings

There were no systems in place to identify the areas of concern we found during our inspection. For example, there were no systems in place to monitor the call times people received, the incident and accidents that occurred within people's homes or complaints. There was also no audit of people's records taking place so when concerns were documented in daily notes there were no systems to identify these so that appropriate action could be taken. The provider showed us a monthly audit that was taking place. This was a tick sheet that had a yes or no response. This looked at body maps and fluids for example. There was no other information recorded and boxes were not often ticked. The provider did not do anything with this information so there were no systems to drive improvement when needed.

The provider sought feedback from people and relatives who used the service. The information they received was positive. However, they had not collated this information to show people's response or fed back this information to participants of the survey.

As noted in 'Safe', when incidents had occurred we did not see action was taken to mitigate further risks. For example, when incidents or accidents had occurred these forms had been filed away into individuals files. There was no evidence of any follow up recorded and the information had not been collated together so that it could be used to drive improvements within the service. For example, when falls had occurred there was no analysis of this stating the total for the month or the amount of people this had affected. This demonstrated that when action was needed to reduce future risks this was not taken.

We found that when information had been received by the provider about staff's potential lack of suitability to work within people's homes they had not completed the necessary checks and relevant risk assessments. The manager and provider confirmed this to us. This meant the provider did not have a suitable recruitment process in place.

We could not sure records were stored securely. People's care files were stored on a shelf in the office and were not locked away. Furthermore on occasion the provider had to leave the office to collect records from another area where they were being stored. This meant people's rights to confidentiality were not maintained.

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

There was a manager in place who had applied to register with us. When we spoke with the manager and the provider they did not demonstrate an understanding of the regulated activity they were registered to deliver. We could not be assured that the provider understood the responsibilities of their registration with us. At the inspection we found there were safeguarding concerns that had not been identified by the provider. The management systems that were in place did not identify these as concerns and the provider had failed to notify us of these events.

Although staff felt supported by the provider and manager, throughout our inspection we raised concerns with both the provider and manager about our findings. Both were unable to demonstrate that they were aware of concerns we identified in relation to the support people received. They had not assured us that staff had the necessary information available so that they could offer the required levels of support to people. They did not demonstrate to us they understood the importance of this or offer reassurances that they knew what action they needed to take. The manager told us they did spot checks on staff in people's home however there was no evidence as to how this information was used to make improvements in the quality and safety of the service. This demonstrated there was a lack of leadership within the service.

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 Staff did not have the information to deliver care in an individualised way. People's cultural needs had not been considered.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked the capacity to make certain decisions, this had not been assessed to demonstrate any decisions made were in their best interest.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Individual risks to people were not considered or reviewed. When accidents or incidents occurred, there were no current systems in place so that improvements could be made and lessons learnt. The provider did not have effective systems to assure us that people received their medicines safely and as prescribed.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We could be sure people were always protected

from potential abuse.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no procedure in place to manage complaints.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no systems in place to drive improvements within the service. The provider sought feedback from people who used the service however this information was not used to make improvements where needed. We could not be assured about staffs suitability to work within the home. We could not be sure we were notified of significant events that occurred within the home. There was lack of leadership within the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not receive their allocated call times.

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 Individual risks to people were not considered or reviewed. When accidents or incidents occurred, there were no current systems in place so that improvements could be made and lessons learnt. The provider did not have effective systems to assure us that people received their medicines safely and as prescribed.

The enforcement action we took:

Notice of Proposal - The registered provider must not provide personal care to any new service user without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no systems in place to drive improvements within the service. The provider sought feedback from people who used the service however this information was not used to make improvements where needed. We could not be assured about staffs suitability to work within the home. We could not be sure we were notified of significant events that occurred within the home. There was lack of leadership within the service.

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