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Care Assistance

Inspection report

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Tel: 01709543361

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

The inspection took place on 28 July 2017 with the provider being given short notice of the visit to the office in line with our current methodology for inspecting domiciliary care agencies. The service was last inspected in July 2016, and was given an overall rating of "requires improvement." Three breaches of regulations were identified at that inspection, relating to; how the service was managed and the governance arrangements; how medicines were managed; and the service's recruitment arrangements.

Care Assistance provides personal care to people living in their own homes in the Rotherham and Sheffield areas. At the time of the inspection the provider was providing care services to 67 people.

The provider was registered as an individual, meaning that there was no requirement for a registered manager.

People we spoke with told us the service, and the care staff, were extremely caring. One person said: "They really are lovely, I couldn't be without them." Another said: "I'm very satisfied, they are all great girls." The provider had received various compliments and thank you notes from the relatives of people using the service, with one saying: "If all care companies were like yours then the care in this country would be first class."

People's care and progress was monitored by means of regular reviews, so that the provider could respond to any changes, altering care packages as required to ensure people's needs were met. However, we saw that records were not always updated to reflect this.

We identified improvements to the way that recruitment was managed within the organisation, meaning that recruitment decisions were safe.

There was a safeguarding policy and clear procedures for staff to follow if they suspected abuse. All staff had received training in relation to this. However, we found that the provider had not followed correct procedures when dealing with an allegation of abuse.

Medication records had improved since the last inspection, but there were still improvements to be made.

The provider had not followed the correct, legally required, procedures when obtaining people's consent to their care and treatment. Where people lacked the capacity to give consent, the provider was unaware of the steps they were required to take.

Staff told us they felt well trained to do their jobs, although we noted there were some key areas of training that staff had not received.

The provider was failing to carry out sufficiently robust audits to ensure that shortfalls or concerns were

identified and addressed. The provider did not have a system in place to monitor the quality of service provided, and could not evidence that it was complying with the law in this area.

You can see what action we told the provider to take at the back of the full version of the report. We are taking enforcement action against the provider, and will report on this at a later date.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

We identified improvements to the way that recruitment was managed within the organisation, meaning that recruitment decisions were safe.

There was a safeguarding policy and clear procedures for staff to follow if they suspected abuse. All staff had received training in relation to this. However, we found that the provider had not followed correct procedures when dealing with an allegation of abuse.

Medication records had improved since the last inspection, but there were still improvements to be made.

Requires Improvement ●

Is the service effective?

The service was not always effective.

The provider had not followed the correct, legally required, procedures when obtaining people's consent to their care and treatment. Where people lacked the capacity to give consent, the provider was unaware of the steps they were required to take.

Staff told us they felt well trained to do their jobs, although we noted there were some key areas of training that staff had not received.

Requires Improvement ●

Is the service caring?

The service remains good

Good ●

Is the service responsive?

The service was responsive.

People's care and progress was monitored by means of regular reviews, so that the provider could respond to any changes, altering care packages as required to ensure people's needs were met. However, we saw that records were not always updated to reflect this.

Good ●

Is the service well-led?

The service was not well led.

The provider was failing to carry out sufficiently robust audits to ensure that shortfalls or concerns were identified and addressed. The provider did not have a system in place to monitor the quality of service provided, and could not evidence that it was complying with the law in this area.

Inadequate ●

Care Assistance

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 was 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.

The inspection included a visit to the agency's office which took place on 28 July 2017. The provider was given short notice of the visit in line with our current methodology for inspecting domiciliary care agencies. The inspection was carried out by an adult social care inspector.

To help us to plan and identify areas to focus on in the inspection we considered all the information we held about the service, including information gained from people using the service and their relatives who had contacted CQC to share feedback about the service. We contacted one of the organisations who commissioned the service to seek their views about the service provided, and spoke with a sample of people using the service, their relatives and care workers by telephone. During the inspection we spoke with the provider and a senior staff member. Before the inspection, the provider completed 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.

During the inspection site visit we looked at documentation including care records, risk assessments, personnel and training files and other records relating to the management of the service.

Is the service safe?

Our findings

When we inspected the service in July 2016, we judged that the provider "requires improvement" for this domain. We identified concerns in relation to recruitment and medication records. We told the provider that they must make improvements in relation to these areas, and they supplied an action plan setting out what steps they intended to take.

People using the service told us they felt safe when receiving care from the provider. One person told us; "I have nothing to worry about when they [the care workers] are here, I'm perfectly safe with them."

We checked to see whether care and support was planned and delivered in a way that ensured people's safety and welfare. We looked at seven people's care plans and found that each person had been assessed in relation to any risks they may be vulnerable to, or may present. These risk assessments set out how staff should provide care and what steps they should take to ensure that the person was cared for safely.

The care records we checked showed that an environmental risk assessment had been completed for people's homes in order that staff could work safely in them. The risk assessments included any safety hazards, potential risks and safety information such as where fuse boards and meters were located in people's houses. This ensured that the provider was able to identify any potential risks in the person's home that could have an impact on staff carrying out their duties, or on the person themselves.

Policies and procedures were available regarding keeping people safe from abuse and reporting any incidents appropriately. The staff we spoke with told us they had received training in safeguarding, and the provider's training records supported this. There had been an incident prior to the inspection which had been alerted to, and investigated by, the local authority's safeguarding adults team, however, the provider had failed to submit the legally required notification to CQC in relation to this.

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

We checked a sample of staff files and found that improvements had been made since the last inspection. Before any appointment was made, two references were obtained including one from the staff member's most recent employer. Each staff member provided evidence of their identity and a full employment history.

Records we checked showed that all staff had to undergo a Disclosure and Barring (DBS) check before commencing work. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults.

We found there was a policy in place to guide staff in how to support people using medicines, including in relation to recording and storing. However, we noted that medication records were not always kept adequately. For example, some people required topical medications, often in the form of creams. Where staff were applying this there was no medication administration record to show which staff member had

carried this out and staff had not always signed to say whether other medications were administered. We also found that medication administration records were completed by hand rather than by the prescribing pharmacist, but staff had not signed to show who had taken responsibility for the accuracy of such records.

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

Is the service effective?

Our findings

People we spoke with told us they felt the care they received met their needs. One person told us that they could contact the office whenever they wanted if they needed to change anything, and a relative we spoke with told us that care staff had a good understanding of their relative's preferences and care package.

There was a programme of documented spot checks in place, carried out by the provider or senior staff. Part of the spot check process included assessing whether the person's current care package was meeting their needs effectively, and whether any changes were required.

Staff training records showed that staff had training to meet the needs of the people they supported. The provider had an induction programme and mandatory training, which all staff were required to complete. Staff confirmed to us that they had undertaken training in safeguarding, medicines management and first aid, amongst other areas. However, we noted that there were some fields of training that a large number of staff had not undertaken. For example, one person's care records showed that they needed assistance with catheter care on each care visit. We cross-checked the records of staff who had carried out care visits with the provider's training matrix and found that not all staff had received training in relation to catheter care. We also saw that most staff had not been provided with any training in relation to the Mental Capacity Act.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We checked whether people had given consent to their care, and where people did not have the capacity to consent, whether the requirements of the Act had been followed. We saw policies and procedures on these subjects were in place, however, the provider was not complying with the MCA or its own policies and procedures. None of the seven care files we checked contained any mental capacity assessment, so it was unclear whether people had the capacity to consent to their care and treatment. In one person's file, a relative had given consent on their behalf. The provider told us that this was because the relative had the power of attorney enabling them to do so, however, we checked with the person's relative and found that this was not the case, meaning that this consent was unlawful.

The provider told us that some of the people using the service did not have the mental capacity to give consent, however, in these cases there was no evidence that decisions about their care had been made in accordance with the best interest arrangements set out in the Mental Capacity Act Code of Practice. We discussed this with the provider and they described that this was something they were not aware of.

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

The care plans we checked showed that, where people required assistance with meals, for example by staff making a meal for them or by staff prompting them to eat, there were details for staff to follow. We looked at

people's daily notes, where staff recorded the care they had provided, and saw that they were supporting people in relation to food and drink in accordance with their care plans.

Is the service caring?

Our findings

When we inspected the service in July 2016, we rated them "good" for the domain of caring.

People we spoke with told us the service, and the care staff, were extremely caring. One person said: "They really are lovely, I couldn't be without them." Another said: "I'm very satisfied, they are all great girls." The provider had received various compliments and thank you notes from the relatives of people using the service, with one saying: "If all care companies were like yours then the care in this country would be first class."

We spoke with staff, some of whom had previously worked for other care companies. One told us that they felt Care Assistance afforded them "time to care" which contrasted positively with their experience of other providers. Another staff member said: "The staff here really do care, that's the difference."

Files we checked showed that each person had a detailed document setting out exactly how staff should provide their care. Including details of personal preferences. The provider described that this document was developed with involvement from the person concerned although the documents we checked had not been signed by the person concerned to confirm this. The provider told us that where people could not describe their preferences this information had been sought from their relatives.

We checked daily notes, where staff record the care provided, and found that this was in accordance with the care plans. We did note that at times this lacked detail which we raised with the provider on the day of the inspection.

Is the service responsive?

Our findings

When we inspected the service in July 2016, we rated them "requires improvement" for the domain of responsive, and found that they did not have appropriate arrangements in place for managing complaints.

At this inspection we looked at records of complaints held by the provider. There had been one formal complaint received within the 12 months preceding the inspection. The records show that this had related to a staff member not remaining for the duration of the care visit. The provider investigated this, and held a discussion with the care worker involved.

There was a complaints policy which set out how complainants could make a complaint to the provider, and what timescales responses would be made in, although we noted that it did not contain the correct route of external remedy. At each review of people's care, the manager leading the review checked whether people were happy or had any concerns or complaints about their care.

We checked seven care files, and saw they contained detailed information about all aspects of the person's needs and preferences. The provider had conducted assessments of these preferences before people started to use the service, consulting people and their relatives. Records included clear guidance for staff in relation to how people's needs should be met in accordance with their care assessments. These were set out in a good level of detail so that staff understood what was required.

There was a programme of reviews of care, in which the provider or senior staff met with the person using the service and, where appropriate, their relatives, to discuss how their care was progressing and whether any changes were needed. We found that the response to changes was not always documented adequately, however, the provider understood each person's care package to a high level of detail, and was very familiar with any changes. We discussed with the provider on the day of the inspection the importance of documenting changes so that each person's care documents represent an accurate record.

Is the service well-led?

Our findings

When we inspected the service in July 2016, we found concerns in relation to how the service was run, including a lack of audits leading to a failure to identify and address shortfalls. We judged that the provider "requires improvement" in this domain. We told the provider they must improve this, and they submitted an action plan setting out that all identified shortfalls in the service would be addressed by November 2016.

People we spoke with told us that they felt they knew the provider well, and they were always accessible to them. They told us they wouldn't hesitate to contact the provider if they needed to speak with them. Staff told us the provider was very supportive, with one saying the provider was "like a mother" and another saying the provider was "really kind, lovely."

We looked at how medication was audited at the service. The provider's action plan stated: "November 5th we will follow our audit system and collect all our MAR sheets and make sure our medication information is up to date." However, the provider told us that these audits had not taken place.

We identified errors in the way medicines were recorded, including a lack of medication administration records for some medicines, staff failing to sign when they had administered medicines and a lack of signatures on hand written medication records, meaning there was no accountability as to the accuracy of these records. As there had been no audit of medicines, these concerns had not been identified or addressed.

Many of the care plans we checked contained incorrect information, including in relation to how consent was obtained, and staff had not always fully completed people's daily notes. We asked the provider how care plans were audited. They told us that this was done by reading and checking care plans, however, there was no formal audit in place, and no recorded details of what should be checked. This meant that the errors and omissions had gone unaddressed.

Feedback from people using the service was obtained via regular spot checks, and recorded in the spot check documentation. We asked the provider how this feedback was assessed, but they told us this was done informally and there was no system of analysing trends or developing service improvements arising from people's feedback.

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

It is a legal requirement for providers to display the rating of their most recent inspection on their premises. We noted during the inspection that the provider was not doing this, and raised this with them. They stated that they were not aware of this requirement, however, we had written to the provider in the previous year setting out this requirement. The provider did not address this breach during the inspection

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the inspection, the provider told us about certain incidents which had occurred within the service. None of these had been notified to CQC, despite it being a legal requirement to do so. The provider told us that they were unaware of this requirement.

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

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider did not have appropriate arrangements in place for obtaining and acting in accordance with people's consent. Where people lacked capacity to consent to their care and treatment, the provider did not comply with legal requirements.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider did not have appropriate arrangements in place to ensure the proper and safe management of medicines.</p>

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 17 HSCA RA Regulations 2014 Good governance The provider's arrangements for assessing, monitoring and improving the quality and safety of services provided were inadequate. The provider had failed to ensure that accurate and complete records in relation to the provision of care were kept.

The enforcement action we took:

The provider's arrangements for assessing, monitoring and improving the quality and safety of services provided were inadequate. The provider had failed to ensure that accurate and complete records in relation to the provision of care were kept.