Q1Care Limited

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Inspection report

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Date of inspection visit:
05 July 2017

Date of publication:
22 August 2017

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

This was a focused inspection, carried out on 5 July 2017 to follow up on concerns raised about the service. The inspection was announced.

The concerns related to the adequacy of employment checks prior to the appointment and deployment of staff. This included, staff working with vulnerable people prior to references being received and disclosure and barring checks being completed. In addition, missed calls had occurred where some people had not received their medicines. It was further claimed that support for staff was on occasions inadequate and that access to senior staff during out of office hours was not always possible. Additional concerns were raised about the adequacy of staff training particularly relating to moving and handling.

Following this focused inspection we found that some of the concerns were substantiated and some were partially substantiated. The service was now in breach of Regulation 19. This related to the lack of robust recruitment procedures which had allowed staff to work with people prior to all necessary checks being in place.

Q1Care Limited is a domiciliary care agency based in Theale, Reading, providing personal care and support to people living in their own homes. A registered manager was in post.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider allowed staff to work at the service on their own without completing all required recruitment checks.

There had been occasions where missed calls had resulted in some people not receiving their medicines.

Is the service effective?

Requires Improvement

Staff shortages and ineffective communication had resulted in some people not receiving care as detailed in their care plan.

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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 on concerns brought to our attention and whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We last inspected the service on 11 August 2016. At that inspection we found the service was good in all domains. That is was the service safe, effective, caring, responsive and well-led. The service received an overall good rating. At this inspection we focussed on specific and limited areas of the safe and effective domains.

This visit took place on 5 July 2017. It was a focused inspection to follow up on concerns that had been raised about various aspects of the operation of the service.

This inspection was announced. The inspection was carried out by one inspector. Before the inspection we sought feedback from the local authority in which the service was located and it was confirmed that they had received no concerns about the service. We checked records relating to the focus of this inspection, such as notifications. Notifications are reports of events that the provider is required by law to inform us about.

During the inspection we spoke with the registered manager and office based personnel and checked records relating to the focus of this inspection. This included care files, records of relevant training, supervision for all staff and relevant documentation. Following the inspection we sought the views of all staff who were actively working at the service.

Requires Improvement

Is the service safe?

Our findings

Concerns were raised from an anonymous source in relation to recruitment practices and missed calls some of which had resulted in people not receiving their medicines. Subsequent information was provided in relation to a lack of moving and handling training for new staff. It was alleged that this had resulted in the resignation of one member of staff who had suffered a back injury.

We spoke with the registered manager, the Human Resources Manager responsible for human resources and tracking recruitment processes. We looked at six staff files in detail and found omissions in relation to the recruitment of three members of staff. These included staff commencing work without references having been received which demonstrated conduct in previous employment. In addition, there was one file where evidence of any previous convictions from the Disclosure and Barring Service had not been received before the person commenced employment. We reviewed the recruitment tracking tool which was overseen by one of the administrators and found further evidence of some staff commencing employment prior to all checks being in place.

This issue was raised at the last comprehensive inspection which was conducted on 11th August 2016. This practice has the potential to place vulnerable people at risk from receiving care from staff not suitable to work in the care industry. This is a breach of Regulation 19 and Schedule 3 in particular and relates to the employment of fit and proper persons. We were assured that since employment none of the staff involved had conducted themselves inappropriately and there was no evidence to suggest there was any cause for concern.

There had been one unique and unusual situation where a replacement staff member had been required at very short notice for a person who required end of life care. The person employed bypassed the normal recruitment procedures due to the urgency of the situation. The dilemma was resolved with the full involvement and agreement of the person's family members. Whilst very careful consideration was taken to assess the risks in this situation the assessment had not been documented. Whilst it was not anticipated that a similar situation might arise the registered manager undertook to ensure that a comprehensive documented risk assessment would be completed in any future incidents.

We discussed the issue of missed medication with the registered manager. She was able to identify two occasions where missed medications had occurred. It was confirmed that in both situations the people lived with other family members who were able to ensure that medicines were administered. The registered manager was also aware of occasions where medicines had been administered but the supporting documentation had not been completed. However, we received information from some staff which indicated that there had been other occasions where missed calls had resulted in medicines not being given. The information received suggested that on at least two occasions missed medicines had been reported to the senior management but it was unclear whether any action had been taken. The registered manager undertook to ensure that all incidents of missed medicines were appropriately recorded and acted upon.

We looked at staff training and in particular the provisions for moving and handling. We saw that staff training for moving and handling had occurred in October and November 2016. This had included all those staff who required the training and who were employed at that time. The registered manager informed us that it had been difficult to access further training for new staff employed since this time. However, she confirmed that no staff who had been employed since November 2016 had been allocated to people who required assistance with moving and handling and would not be until they had received training to ensure they were able to move and position safely.

We found no evidence of any staff member having left as a result of back injury caused in the course of work with the agency. As a result of our visit the registered manager had included theory of moving and handling as part of the induction of new staff which was supported by a dedicated work book. It was planned that this training would be supplemented by practical class room based training when available.

Requires Improvement

Is the service effective?

Our findings

Concerns were raised from an anonymous source in relation to the difficulty in accessing senior on call staff out of office hours, a lack of communication with regards to changes in the rota and insufficient staff numbers. There were also claims of lack of staff support from senior management and a high turnover of staff. It was considered by the person raising the concerns that this had put people at risk of harm due to the inconsistency of staff providing care to people.

We spoke with the registered manager and contacted all current care staff to provide them with an opportunity to give feedback in relation to the concerns. The registered manager told us that they were not aware of any situations where care staff had not been able to contact senior personnel out of office hours. However, she confirmed that there may have been occasions where telephone calls were not immediately answered but return calls would have been made at the earliest opportunity. We received feedback from some staff that there had been occasions where senior staff had not been accessible and calls had gone unanswered. It was not possible from the information received to determine an exact number of the incidents of when this had occurred. The registered manager told us that since moving offices in June 2017 an engaged tone was activated when the on call phone was in use. It was thought that previously a caller would just hear a ringing tone and not know that the on call phone was in use. The registered manager undertook to further investigate the possibility of a messaging service where out of hours callers could leave a message when the on call phone was in use.

There was evidence that there had been a shortage of staff on occasions in the past and more recently, which had resulted from sickness absences and staff leaving. This had meant that uncovered calls were rescheduled to alternative staff at short notice. These changes had not always been communicated to relevant staff effectively and had resulted in some calls being missed. This was confirmed through feedback from staff. However, from evidence gathered the number of missed calls had been relatively small in number. Following the visit the registered manager confirmed that all staff had been reminded verbally and in writing to always check their rota for the day before commencing their shift. This was to ensure that they were aware of any alterations to their pattern of work. In addition, any changes in timing of calls or additions and cancellations were communicated by telephone and email to ensure that relevant staff were aware of the changes in good time. The registered manager advised that it had not been possible to recruit to a senior co-ordinator role since earlier in the year which would have provided senior management support. This was owing to the absence of the previous post holder who had been away due to long term sickness followed by their subsequent resignation. The registered manager told us that there would be appropriate cover arranged as required and confirmed that they were in the process of an applicant for the position.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person had not ensured that information specified in Schedule 3 was available in respect of staff employed for the purposes of carrying on a regulated activity. The registered person had failed to obtain satisfactory evidence of staff member's conduct in previous employment relating to working with children or vulnerable adults or evidence of any previous criminal convictions. Regulation 19 (1)(a), (3)(a) and Schedule 3 (1-8).