Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Graceful Home Care

85a
High Street
Barry
CF62 7DX

Date Inspection Completed

22/12/2023

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About Graceful Home Care

Type of care provided	Domiciliary Support Service
Registered Provider	GRACEFUL HOME CARE LIMITED
Registered places	0
Language of the service	English
Previous Care Inspectorate Wales inspection	This is the first inspection carried out.
Does this service promote Welsh language and culture?	This service does not provide an 'Active Offer' of the Welsh language and does not demonstrate a significant effort to promoting the use of the Welsh language and culture.

Summary

Graceful Home Care is registered with Care Inspectorate Wales (CIW) to provide a domiciliary support service within the Cardiff and Vale regional partnership area, with its office based in Barry. This visit was unannounced, and the first inspection carried out since registration.

Rebecca Van Praag is the Responsible Individual (RI) for the service, who oversees the strategic operation of the service. At the time of this visit, a manager was in place who is registered with Social Care Wales, the workforce regulator, in accordance with legal requirement. The manager was not available at the time of the inspection visit.

People receive care and support from a staff team who are kind but who have not undertaken the appropriate training for their identified risks and needs. The provider could not evidence suitable levels of training, development opportunities and support for care workers and the manager. Effective systems are not in place to ensure the quality of care and support are provided in accordance with people's identified care needs and risks. Safe recruitment processes are not in place.

Well-being

People are not always at the heart of the service and measures are not in place to provide good standards of practice. Care documentation to ensure the care provided is person-centred and safe according to peoples' needs was unavailable. We were told by the responsible individual they had been unaware that care documentation including medication administration charts and care records were not in place in peoples home as required. We were told by the responsible individual (RI) that efforts to provide all care documentation were being carried out as a priority to remedy the situation.

People cannot be fully assured they receive care from trained and competent staff. We found staff had undertaken minimal online training in some areas and no practical training had been carried out from accredited and competent sources. We examined the staff training matrix and found there were gaps in the provision of core training such as medication and manual handling which would be required for staff to perform their role and meet the needs of the people they support safely. Essential training had not been carried out. Recruitment processes are not in place to ensure staff have been sufficiently checked prior to commencing employment at the agency. These measures are important to protect people who may be vulnerable and protect care workers.

People using the service cannot be assured that there is robust and competent leadership and management of the service at this time. We examined the statement of purpose document which outlines the service's philosophy of care. Our review of the care documentation, the lack of training and poor recruitment practices do not demonstrate the service actively seeks to put the statement of purpose values into practice. Systems and processes which promote the smooth running of the service are not in place to monitor quality and practice and identify and address any deficits. For example, the provider was unable to demonstrate whether calls were being delivered on time or lasting the duration required because the electronic monitoring system in place had not been used in the way it was intended. The RI was aware that at least one call had been late but could not be certain that there were not other instances. It is important to have safe systems in place to alert managers at the service if there are problems delivering care on time. Some people may not be able to report missed or late calls themselves and could experience feelings of anxiousness or be at risk of harm.

Those care workers we met spoke of the people they supported with care and fondness, as did the RI. They demonstrated a passion and commitment to make improvements to the service so they could deliver care and support safely and with expertise to match their kindness.

Care and Support

A reliable service is not in place. The evidence suggests that people using Graceful Home Care do not receive a service that makes a difference to the lives of people using the service, as their statement of purpose suggests. Care documentation and personal plans were either not available or did not provide sufficient information to enable care workers to deliver care and support safely and well. We were told efforts were underway to provide these as a priority. Personal plans are important documents that should provide detailed information about individuals' needs and advise staff how to look after people in the way they want and need.

We identified some individuals had high risks identified and documented in placing authority information which should have been reflected and planned for in personal plans and risk assessments created by the provider.

Staff did not have the relevant information or training to assist them in promoting and maintaining the safety and independence of people using the service.

We found care is delivered by staff who, although kind and willing to learn, do not have sufficient training and experience. We noted staff had not received appropriate training prior to or after commencing employment and were working with people who needed skilled care to support them with due to health conditions they live with. We found 50% of the care workers had no previous experience of working for a care service.

Training records we saw indicated only some online training had been carried out and only limited induction undertaken. We saw no evidence staff had received infection control training. There has been no practical training carried out for topics such as manual handling from competent and skilled trainers. We discussed this issue with the responsible individual who told us appropriate training would be sought immediately. This is important for staff to gain and maintain skills and knowledge for safe care delivery.

We were informed the agency had an electronic monitoring system, but that this had not been implemented for its proper purpose. Care staff used mobile phones to log in and out of calls on an ad hoc basis. This does not alert the service when a call is missed or late nor does it track the length of the allocated call effectively and consistently to enable the provider to spot any patterns or trends emerging. Therefore, there was no way of identifying any discrepancies such as calls that had not been timely or staff staying the duration of the call. We conclude people do not receive a service they can reliably depend on as it could not be evidenced that calls happen nor if they last the time commissioned.

People cannot be assured that staff are safely recruited and competent to undertake their roles as the recruitment process is not robust. We looked at a sample of staff personnel files and saw the necessary safety checks are not in place to ensure staff's suitability to work with vulnerable adults. Files did not contain the required information including employment history, references, and Disclosure and Barring Service (DBS) information in all cases. We conclude processes are not in place to ensure staff have been 'vetted' in a way that safeguards people. This not only places people using the service at risk, but it also fails to protect care workers who may be unfairly accused of alleged wrongdoing, based upon their past conduct.

We have issued a priority action notice and the provider must take immediate action to address the above issues.

Environment

This theme does not apply to domiciliary care agencies.

Leadership and Management

People using the service cannot be assured that there is robust and competent leadership and management of the service. This is because the provider has failed to undertake effective governance and oversight of the actions and omissions of the people employed by them.

We examined Graceful Home Care's statement of purpose document which should outline the service's philosophy of care. The document stated that the service is "*Committed to providing high quality domiciliary care*". However, our review of the care documentation and the overall running of the service has not demonstrated that the service actively seeks to put these values into practice. Systems and processes that help promote the smooth running of a service, and internal audits to monitor standards and practice, have not been carried out.

People cannot always be confident that they will receive all information that should be available to inform them about what the service can provide. We saw that the statement of purpose contained some information that informed people, but we recommend that additional information be included to meet regulatory requirements such as an accurate description of the services provided.

We did not see evidence of audits undertaken and the service must improve its internal quality systems. For example, we were told by the RI that they had not undertaken any regular audits of people's care documentation nor staff personnel files since the service commenced. There was no evidence to indicate that the manager, and others, had undergone a suitable recruitment process, induction, nor probationary support. The RI told us they assumed, rather than tested, that essential actions concerned with the management of the service had been undertaken and had not checked until a matter was brought to their attention by CIW to investigate. This prompted a closer look, by the RI, at the service delivery. The service did not keep copies of medication records/care records at people's homes to guide and support care staff and enable people to contribute to understanding and recording their care. The RI told us this matter is being addressed. The provider must enhance and improve systems and processes to inform quality assurance. Given the lack of documentation/information available and the potential risks to people using the service the Local Authority has worked closely with the RI to resolve matters quickly and safely. The provider has co-operated with CIW and other professionals to make improvement.

We have issued a priority action (non-compliance) notice, and the provider must take immediate action to address the above issues.

Summary of Non-Compliance	
Status	**What each means**
New	This non-compliance was identified at this inspection.
Reviewed	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
Not Achieved	Compliance was tested at this inspection and was not achieved.
Achieved	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

Priority Action Notice(s)		
Regulation	Summary	Status
6	The provider is non-compliant as they have failed to conduct and manage the service with due care, competence and skill.	New
36	The provider is non-compliant as they have failed to ensure staff receive appropriate training appropriate to the work undertaken by them .	New
35	The provider is non-compliant because they failed to ensure appropriate pre- recruitment checks were carried out for staff working at the sevice.	New
8	The provider has failed to ensure that there are effective arrangements in place for monitoring, reviewing and improving the quality of care and support provided by the service.	New

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

Area(s) for Improvement		
Regulation	Summary	Status
N/A	No non-compliance of this type was identified at this inspection	N/A

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