Mrs Charity Kelechi Earnshaw

Charity Earnshaw

Inspection report

High View (off Greenbank)
High Street, Newton Poppleford
Sidmouth
EX10 0DZ

Tel: 07482167528
Website: www.charityearnshaw-homecareagency.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Charity Earnshaw is a domiciliary care service, supporting adults in the community who require assistance with personal care. This included people living with dementia, physical disabilities, mental health needs and sensory impairments. At the time of our inspection there were 24 people who used the service supported by 14 staff.

People's experience of using this service and what we found.
Prior to our inspection we found peoples experience of the service was poor and made a number of safeguarding referrals. A whole service safeguarding enquiry was in progress with the local authority. A suspension of local authority placements was in place, and a voluntary suspension of new private placements.

Risks were not well managed. Risk assessments did not consistently provide the information staff needed to understand and minimise risks. There were no systems in place to ensure people would not be placed at risk if there were any problems affecting service provision, such as Covid-19, staff sickness or adverse weather conditions.

Concerns about people's health and safety had not always been escalated by staff, and not all staff we spoke with were aware of the processes for doing so. External health professionals and relatives told us the provider did not always work effectively with other agencies to provide safe and effective care. Safeguarding concerns had not always been managed appropriately and had not been reported to the local authority or the Care Quality Commission. Safeguarding policies and procedures were out of date.

The administration of medicines was not safe because staff had not always had the necessary training or their competency checked. There were no processes in place to audit the safety of medicines administration. This meant medication errors had not always been identified or reported to safeguarding as required.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff had not received the induction, training and support required to develop and maintain their professional skills. Not all staff, including the provider, had completed training in infection control, and there had been a significant delay before staff received specific Covid 19 infection control training. The provider had not maintained their knowledge and skills or kept themselves up to date with best practice guidance. This meant they were unable to ensure care delivered by their staff group was in line with good practice standards, guidance and the law.

The provider did not have adequate systems in place to monitor and review the quality of care and ensure the service was meeting people's needs safely and effectively. Policies and procedures were out of date and not always relevant to the type of service being provided. They were not always well understood and followed by staff.

The service had expanded significantly since the last inspection. When we inspected in June 2019, 18 people were being supported. By August 2020 this had increased to 33 people. The staff team had increased from five to 14. The provider told us the training and development of the staff team and service had been delayed as a result of the pandemic and lock down.

The provider and staff team were committed to improving the quality and safety of the service. One member of staff told us, "A lot of things need to be updated. I know the provider is doing their utmost to get everything in place. I'm happy now it's being put in place. It's improving."

The provider was working with the local authority quality assurance and improvement team (QAIT) to identify and make the necessary improvements. They had drawn up a service improvement plan. This identified the actions needed, who was responsible for them and the progress being made. New policies and procedures were being introduced and quality assurance tools developed.

Staff were in the process of completing relevant training. Spot checks and staff supervisions had recently begun. Risk assessments, care plans and mental capacity act assessments were being reviewed by the newly recruited senior carer.

Overall people spoke positively about the service. However, although there were some recent improvements in the way the service was managed and run, these were not effective or embedded.

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

Rating at last inspection: The last rating for this service was good (published 11 July 2019)

Why we inspected:
We undertook this targeted inspection to follow up on specific concerns we had received about the safety and quality of the service. These concerns were subject to individual and whole service safeguarding investigations. A decision was made for us to inspect and focus on the management of risk, staff training, medicines administration and quality assurance. During the inspection, we found additional concerns related to protecting people's human rights; the management of safeguarding and the knowledge and skills of the provider. We therefore widened the scope to become a focused inspection which included the key questions of Safe, Effective and Well-led.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Charity Earnshaw on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We found the issues identified were not caused by the pandemic.

We identified five breaches in relation to risk management; the administration of medicines; staff training and support; consent; working with other agencies; notifications and overall governance.

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.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner.

Special Measures:
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.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below

Charity Earnshaw

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Two inspectors completed the inspection.

Service and service type
This service is a domiciliary care agency. At the time of the inspection 14 staff were providing personal care to 24 people living in their own houses and flats. The provider is also the manager and is registered with the Care Quality Commission. This means they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection so we could arrange infection control measures because of the Covid-19 pandemic.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We attended safeguarding meetings led by the local authority. We sought feedback from the local authority and health professionals who work with the service. We used all of this information to plan our inspection.

During the inspection

We spoke with five relatives and two people using the service by telephone. We spoke with the provider/registered manager and six staff, including office staff and care staff. We reviewed four care records, four recruitment files, induction and training records, and accidents/ incidents forms. We were shown the proposed quality assurance tools on the computerised care planning system. We also checked people's medicine administration records.

After the inspection
As part of the inspection, we requested and received copies of the service improvement plan, audits, care plans, staff rotas and monitoring checks connected to the running of the service and people's welfare. We had feedback from three health and social care professionals. Following the inspection, we provided written feedback and met virtually with the provider and office staff.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider had failed to ensure risk assessments were consistent and accurate. This meant staff were not provided with effective guidance to reduce and minimise risks to the people they supported.
- We reviewed risk assessments where people had been identified as being at high risk due to malnutrition. They were documented as eating poorly, but their weight was not known. This meant it was not clear whether they were losing weight or if further action was required to minimise the risks.
- Staff said one person's behaviour frequently became physically and verbally challenging. There was no guidance for staff about how to safely support the person.
- Some people refused to be supported, to eat or take their medicines. There was no detailed guidance for staff about how to work with them and encourage them to accept support, so their needs were not met.
- There were no systems in place to address Covid 19 issues, staff sickness and adverse weather conditions. This put people at risk of an unsafe or unreliable service.

These examples are a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some of the above risks were reduced because the majority of the staff team knew people well and had a good understanding of their needs. Risk assessments and care plans were in the process of being reviewed, Emergency plans were being developed to manage risks affecting service provision. Staff were due to receive training to support them to monitor weight loss.

Using medicines safely

- The systems for ensuring medicines were administered safely were ineffective.
- Staff had recently completed online training in the safe administration of medicines. However, records showed some staff had previously administered medicines prior to completing any training, which put people at risk.
- The provider did not check the competency of staff to ensure they had the skills and knowledge required to administer medicines safely. It was not possible for them to do this until they and other senior staff had completed training to enable them to do so.
- Medication administration was unsafe because there were no quality assurance checks. This meant it was not always possible to tell if people had received their medicines as prescribed. Medication errors had not always been identified or reported to safeguarding as required.

This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

●Actions were planned to mitigate the risks related to unsafe medicines administration. For example, additional training in medicines administration and competency checks was being arranged. Staff were going to be reminded of the need to complete the MAR. A formal auditing process was being set up on the computerised care planning system.

Learning lessons when things go wrong
●Staff did not always have a clear understanding of the policy and processes in place for managing accidents and incidents.
●We observed staff escalating concerns to the office, and referrals made to health and social care professionals when required. However not all staff were aware of this system, how it worked and when to escalate concerns. This meant concerns about people's health and safety had not always been escalated.
●There was no system in place for the provider to review accidents and incidents to determine what worked well, lessons learnt, and improvements needed to minimise the risk of recurrence.

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

●The provider and senior staff were committed to making the necessary changes to keep people safe. They were working with staff to support them to understand how to recognise, record and escalate concerns. Quality assurance systems were being developed to monitor the safety of the service.
Systems and processes to safeguard people from the risk of abuse
● People had not always been safeguarded from the risk of abuse. Safeguarding concerns had not always been managed appropriately and reported to the local authority or the Care Quality Commission. During the safeguarding process the provider did begin sending safeguarding referrals to the local authority
●Safeguarding policies and procedures were out of date.
● Overall people told us they felt safe being supported by the care staff. Staff undertook training in how to recognise and report abuse. They said they would have no hesitation in reporting any concerns and were confident that action would be taken to protect people. Safeguarding policies and procedures were being reviewed and updated.

Preventing and controlling infection
●People had not always been protected from risks related to the spread of infection.
●Not all staff, including the provider, had completed general training in infection control. A complaint from a relative demonstrated not all staff were aware of the measures necessary to keep people safe from Covid 19.
●We discussed this issue with the provider. All but three staff had now completed Covid 19 specific training. Staff had been kept informed of relevant guidance from Public Health England by email and at staff meetings. They had all been provided with the recommended PPE. All visitors to the office had their temperature checked on arrival.

Staffing and recruitment
● Overall people said the service was reliable. One person told us, "I have no objections. They turn up on time. They are nice carers, very helpful…I have a list of who is coming and what times and they turn up on time."
● The provider ensured all new staff were checked to make sure they were suitable to work at the service. This included Disclosure and Barring Service checks (DBS). The DBS checks people's criminal history and

their suitability to work with vulnerable people.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- The service did not always ensure that it obtained people's consent to care and treatment, and staff were unclear about the requirements relating to consent. The provider did not check or audit consent activity.
- Consent to care and treatment and best interests' decisions had not been obtained in line with legislation and guidance, including the MCA. Mental capacity act assessments completed by the provider were not decision specific. They concluded the person did not have capacity and their family were in charge. The newly recruited senior carer had recently reviewed and updated the mental capacity assessments in relation to a general decision of 'personal care'. However, the assessment was still not decision specific, not completed in consultation with others, and did not provide any detail on how best interest decisions were made.
- Consent forms were in place related to the sharing of information. However, it was not always clear from the signed consent form whether the person had consented or not.

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

- The provider and senior staff. acknowledged that further work was required to ensure they were working within the principles of the MCA.

Staff support: induction, training, skills and experience

●Until recently staff had not received the induction, training and support required to develop and maintain their professional skills. This impacted on people's safety. A health professional said, "One person declines a wash and support with their personal care. The staff don't have the skills to engage and support with this. They just ask and the person says 'no'."
●A complaint from a relative expressed concern about a care worker's "very unusual lifting techniques, washing and an apparent lack of understanding when to encourage X to eat." A health professional was concerned about staff knowledge of wound management.
●Staff told us they had received a minimal induction, which consisted of two or three days shadowing other staff. This did not give them the knowledge and confidence they needed to support people effectively, especially when they had no previous experience of working in care.
●Staff had not received the regular training required to allow them to meet people's needs safely and effectively. For example, they had not been adequately trained in moving and handling people. This meant they did not always have the knowledge and skills to use equipment prescribed by external health professionals.
●Staff had not been supported through regular supervision and appraisal, or observations of practice. This meant the provider did not monitor care practices or identify strengths and learning needs.

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

●Action was being taken to improve training and support for staff. An induction programme was being developed. Staff had recently competed practical training in moving and handling, personal care, privacy and dignity, and catheter care. Specialist training in stoma care was being arranged. A training matrix showed staff were working through a range of on-line training. However, several staff had yet to complete training in first aid, falls awareness, MCA and pressure area care.
●A senior care worker had been recruited with responsibility for carrying out spot checks and supervising staff, and this work had begun.
●Overall people and staff spoke positively about the training. One person told us, "Carers have had lots of training recently. They wear appropriate PPE." A member of staff commented, "The training is good. We are due some more in November. It's getting better. In time it will be fantastic. We need time to get it all in place."
●Some people and their relatives provided positive feedback, which included, "There are some very good carers" and, "I have found them very good. X is very stubborn, but the carers have got X to wash and this has also improved X's independence. X is well looked after. You can give them a gold star from me."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●The provider did not have an effective system to holistically assess people's needs and develop care plans and information which were accurate. Staff descriptions of people's support needs did not always reflect the information in the care plan, for example relating to refusing food or support with personal care.
● An assessment completed by the local authority in April 2019 contained important information about changes to one person's level of risk. The provider had not transferred this information to the care plan. This meant not all staff were aware when a person's informal carer was no longer able to support the person safely.
●The provider was unable to ensure care was delivered in line with standards, guidance and the law because they did not have the relevant knowledge and skills. For example, they had trained staff in moving and handling but were not qualified to do so. This meant people were at risk of unsafe care.

This is a breach of Regulation 12 (Safe care and treatment) 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

●The provider did not always work effectively with other agencies to provide safe and effective care. For example, a relative said the provider, "lacks knowledge of other professionals involved in X's care."

●Referrals to external health professionals were not always made in a timely way when people's needs changed. For example, when a person experienced a deterioration in their mobility.

●A health professional told us the provider, "doesn't listen and doesn't take advice." They had worked with the provider to support a person living with dementia through a big life change. They had discussed beforehand how to minimise the stress of this for the person. However , the provider had not followed their guidance, potentially increasing the persons distress..

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

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

● Staff supported people to eat and drink safely. People at risk of choking had been assessed by the speech and language therapist (SALT) team. Care plans contained clear guidance and staff described how they followed this. Food and fluid charts were kept monitoring their intake.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong. Continuous learning and improving care

- The service was unsafe, ineffective and was not well-led as shown by the high number of breaches of regulation. A whole service safeguarding enquiry was in progress with the local authority. A suspension of local authority placements was in place, and a voluntary suspension of new private placements.
- The provider had not recognised the quality of the service had significantly deteriorated and had therefore put people at risk of unsafe care. They had only begun to make improvements when other agencies became involved through the safeguarding process.
- The service had expanded significantly since the last inspection. When we inspected in June 2019, 18 people were being supported. By August 2020 this had increased to 33 people. The staff team had increased from five to 14. The provider told us the training and development of the staff team and service had been delayed as a result of the pandemic and lock down.
- The provider did not have adequate systems in place to monitor and review the quality of care and ensure the service was meeting people's needs safely and effectively.
- There was no system in place to check the competency of staff in administering medicines and the completion of medicines administration records. This meant people were at risk from unsafe medicine administration.
- There were no formal processes to check the quality and accuracy of risk assessments and care plans. This meant people were at risk because staff did not have the guidance they needed to support people safely.
- Referrals to the local safeguarding team had not been made until prompted by the safeguarding process. There was no system in place for the provider to review safeguarding concerns, accidents and incidents. This meant they were unable to determine what worked well, lessons learnt, and improvements needed to minimise the risk of recurrence
- Policies and procedures were out of date and not always relevant to the type of service being provided. They were not always well understood and followed by staff. For example, the complaints policy stated, "In all cases complaints and concerns shall be treated in a sensitive and confidential manner." However, a relative told us, "I find [the provider] abrupt and when you raise something, they do not take any notice."
- The provider had not kept their own training up to date and was not clear about their regulatory responsibilities. Mental capacity act assessments demonstrated they did not have an understanding of this legislation.

These examples are a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We discussed these issues with the provider and senior staff team. The provider was undertaking training which would enable them to be more effective in their role and deliver training to the staff team. A service improvement plan gave timescales and clarity around responsibilities within the staff group.
●The provider planned to use the computerised care planning system to develop their quality assurance programme. This included timings of visits and the percentage of care tasks documented as completed.
●An up to date set of policies was being developed. They were in the process of being adapted and embedded.
●A senior carer had been recruited to monitor staff practice and provide support. This included training to use the computerised care planning system effectively and raise alerts when there were concerns. They told us, "I am enjoying my role and hope I can bring my knowledge across to support carers to improve their performance."

●Registered providers and registered managers have a legal responsibility to inform us (CQC) about any significant events that occur including any serious injuries or safeguarding events. The provider had failed to ensure this had happened.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4): Notification of other incidents

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Overall staff were positive about the service and the changes being made. Comments included, "A lot of things need to be updated. I know the provider is doing their utmost to get everything in place. I'm happy now it's being put in place. Its improving" and, "We are going to turn it around and get back on track. [The provider] is a good person and really cares. They do hands on care and are a hard grafter. We needed some more staff who knew what they were doing."
●There had been a staff meeting for the whole staff team which staff told us was helpful. This included updates about the proposed training and appraisals, reminders about PPE and recording on the computerised care planning system. Meetings were held for office staff and senior staff, to review progress being made and discuss any concerns.
●People's views had been sought in a quality assurance survey in April 2020. Overall the feedback was positive. Another survey was being sent out in October 2020

Working in partnership with others
●The provider was working with the local authority safeguarding team and quality assurance and improvement team (QAIT) to improve the management of 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 18 Registration Regulations 2009 Notifications of other incidents Failing to notify the Commission about these changes meant we had been unable to monitor concerns and consider any follow up action that may have been required.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive the appropriate training, support and supervision required to undertake their role.

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 11 HSCA RA Regulations 2014 Need for consent Staff did not consistently work within the principles of the Mental Capacity Act (2005).

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always identified, monitored and managed. Medicines were not always managed safely. The service did not always work effectively with other agencies to keep people safe.

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no effective systems in place to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

The service was placed into special measures and a condition imposed on the registration