Eamal Ltd

Caremark Dacorum & St Albans

Inspection report

Enterprise House
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Tel: 01442817117

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03 March 2021
31 March 2021

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Caremark Dacorum & St Albans is a domiciliary care service that is registered to provide personal care to people living in their own homes in the community. At the time of our inspection, 105 people were being supported by the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People told us that staff were kind and caring and they felt safe when receiving their care. However, some people told us that they felt less confident when new staff were sent to support them.

We found that there were mixed experiences from people who used the service with regard to staff using the correct PPE equipment. We have made a recommendation about the management of risks associated with Covid 19.

Where people received support with medicines, this was not always managed safely. Medicines administration records (MAR) were not always completed.

People had mixed views when asked about staff knowledge of their roles. The provider had failed to ensure that all the required recruitment checks were completed prior to staff working at the service. Records relating to recruitment were inconsistent.

The culture at the service was not always open or inclusive. Two people told us they had been asked by staff to provide good feedback on the service to the Care Quality Commission (CQC) and four staff told us they felt there was a bullying culture.

A lack of provider oversight and robust monitoring systems led to some areas of concern not being identified and actioned.

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 10 January 2019).

Why we inspected
We received concerns in relation to the management of medicines, safeguarding, infection control risks, the recruitment of staff, and the culture of the service. As a result, we undertook a focused inspection to review

the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Caremark Dacorum & St Albans 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 monitor the service.

We have identified a breach in relation to the overall governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Caremark Dacorum & St Albans

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
This inspection was undertaken by two inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service notice of the inspection on 02 March 2021. This was because we needed to be sure that the registered manager or a senior member of staff would be in the office to support the inspection.

Inspection activity started on 03 March 2021 and ended on 31 March 2021. We visited the office location on 03 March 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service, received written feedback from a further four people and five relatives about their experience of the care provided. We contacted 53 members of staff and received feedback from 28. We also spoke with the nominated individual and the registered manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also received feedback from a range of people involved with the service. This included three external professionals.

We reviewed a range of records. This included records relating to call times, risk management, safeguarding, medicine records and staff training records. We reviewed five staff files in relation to recruitment, spot checks and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

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 Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Staff told us they were clear about their roles and responsibilities relating to medicines, particularly regarding the safe administration of medicines. One staff member told us, "I have training on administering medication, yes I have been done through spot checks and observations."
- One person was found to have run out of their medicines. A staff member told us they were instructed to sign for this medication by a member of the management team and that they would arrange for the medicines to be administered later. This is not good practice.

Preventing and controlling infection

- We were assured that the provider was accessing testing for staff in accordance with good practice guidance.
- Records showed that staff had completed specific Covid training. However, we received mixed feedback from people with regard to their experiences of how staff used PPE equipment when they supported them.

We recommend the provider ensures they implement current Government guidance with regard to the prevention of risks associated with Covid 19 and update their practices accordingly.

Systems and processes to safeguard people from the risk of abuse

- Staff had received safeguarding training. Staff knew how to identify, and report concerns to management relating to harm. One relative we spoke with told us "I feel confident when leaving (Name) with staff that (Name) is safe, they haven't told me they are unhappy. "However one person we spoke with said "They don't always know what they're doing, that is the newer ones." Not all staff felt that the management acted appropriately to individual concerns raised.

Staffing and recruitment

- The Provider told us that all new members of staff shadow existing team members before they work alone.
- We looked at recruitment information for five staff. In most cases checks had been completed. However, we found that one person had been working without the appropriate checks and monitoring in place. This could have placed people at risk of harm.

- We received mixed feedback from people when asked if they were happy with the support they received. One person told us, "On the whole I feel safe although, sometimes I get inexperienced carers, if that happens in the morning, I don't feel confident to have a shower". Another person told us, "I am quite satisfied with the care; the girls are always pleasant when they arrive."

● Relatives gave positive feedback. One relative told us, "They are very good the carers, and reliable. They are very friendly. They treat [Name] with respect. They wear their PPE. I can always call the office and speak to a member of staff if I need to discuss anything."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.
● Staff told us that each person had individual risk assessments in place. When asked about people, most staff were able to explain each person's risks and identify their individual needs. However, we reviewed a care plan for a person who required moving and handling support and found it failed to provide adequate details on how to fully support the person whilst maintaining their independence. We also found no associated risk assessment in place for this person.

Learning lessons when things go wrong
● We reviewed an example of where the provider had investigated an error with regard to the safe management of people's medicines. We saw from the documentation provided that this was managed effectively and learning points for this were shared with staff.

Requires Improvement

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 Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We found the service was not always open or inclusive. As part of this inspection we contacted people who were receiving a service. Two people told us that staff had informed them that CQC would be contacting them for feedback. One person said [Staff member's name] told me to say everything is good. I felt very uncomfortable." Another person told us that staff insinuated what they should say when speaking with CQC.

● Four staff told us that they felt there was a bullying culture within the service and there was low staff morale and a high turnover of staff. One person told us, "Some of the carers bad mouthed other clients and members of staff." They did not feel this was caring or professional of them. One staff member told us, "There has been a high turnover of staff, which is frustrating because we are having to train and work with those who are inexperienced."

● Some staff also felt they were put under undue pressure. For example, to cover calls even when they were sick. One staff member told us, "If I am ill and ring up with plenty of time before I start work, for example being sick, they will say okay we will try to cover your calls, but can you do the first two calls first."

● People told us they had experienced staff being late to their care calls. Staff told us that they did not always get adequate time to travel to and from different areas. One staff member said, "Travel time is unacceptable. Constantly rushing to get to next client. Seem they want to squeeze as many in before end of shift. Also have been told to cut clients time short to make up travel time." Another staff member told us, "I do not feel that I always have enough time between calls."

● We reviewed care worker rotas for the period between 1st December 2020 to 31st January 2021. We found marked inconsistencies between the timings of calls, distances between calls and the travel times allocated. For example, on 06 December 2020, one care worker started their first call at 06:05. They completed 10 calls that day until 13:50 with only five minutes travel time between each call. This meant that people could not have received their full allocated care hours as there was insufficient travel time provided between each care call, when considering the distance needed to be travelled by the care worker, yet all of these calls were recorded as being completed.

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Some staff raised concerns about inappropriate use of social media which portrayed the company in an

unprofessional manner. This was raised with the provider as part of this inspection. They provided an explanation on how this issue was addressed and resolved.
● A lack of provider oversight and robust monitoring systems led to a failure in identifying concerns in relation to recruitment and infection control. Prior to our inspection some staff told us that they raised concerns but these concerns were not acted upon.

Systems and processes failed to assess, monitor and improve the safety and quality of care being provided or mitigate the risk of harm to people living at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others.
● People gave mixed views regarding being involved and consulted with regard to the care provided. One relative told us, "[Name] said a few weeks ago that they said they don't know what they have done without them as they are like friends." However, another person told us, "When I ring up, it's to cancel a visit. They were not always cancelled, or the wrong days were cancelled."
● At the time of the inspection, there was limited input from other health professionals due to COVID-19 and a reduction on visiting professionals entering people's home. However, as part of this inspection, we received feedback from three external professionals. One professional told us "Personally, I have found Caremark to be very responsive when I have needed to contact them. They have tried to make adjustments to care promptly when I have asked them to, and they have also notified me when they have had concerns about a service user." Another professional told us, "I have been working with Caremark for many years now and find [Registered manager] and her staff to be compassionate, caring and professional."

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 17 HSCA RA Regulations 2014 Good governance Systems and processes failed to assess, monitor and improve the safety and quality of care being provided or mitigate the risk of harm to people receiving a service. Regulation 17 (1) (2) (a) (b)