CSN Care Group Limited

Carewatch (Ipswich)

Inspection report

1a
Norfolk Road
Ipswich
IP4 2HB

Tel: 01473216112

Date of inspection visit:
12 March 2020

Date of publication:
27 April 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Carewatch (Ipswich) is a domiciliary care agency providing personal care to people living in their own homes. 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. At the time of our visit 84 people were receiving personal care from the service.

People's experience of using this service and what we found

We carried out this inspection in response to concerns received in relation to staffing levels and recruitment procedures. We had been sharing these concerns with the provider and asked for investigations to be completed since 20 January 2020. Some of the investigations that had been carried out identified shortfalls and further concerns about the service's safety. The service accepted that there were shortfalls and so we decided to give them time to make some improvements before we visited to inspect and assess how those improvements were going. At the time of our inspection visit a new manager had been in the role one and a half weeks.

Despite input from Suffolk County Council and reassurances from the provider about improvements, we found that the service was not operating in a way which ensured people received the care they required in line with their needs and preferences. Whilst the service told us there had been improvements in reducing missed visits and early/late visits, this was not reflected in records we reviewed at the office which were dated up until 29 February 2020.

The majority of people we spoke with told us the service they received did not meet their needs or preferences. People told us of having visits at times which were not in line with their preferences, having to cancel visits because they were going to be excessively early or late and having visits from staff they did not know which made them feel unsafe. People also told us that rota's they were provided with were sometimes inaccurate as different staff would attend instead of the ones on the rota, without them being informed.

Risks were not assessed or managed appropriately, and systems did not ensure people were always safeguarded from avoidable harm. Medicines were not managed, administered and monitored safely.

We had concerns about the management and oversight of the service, which had previously been rated inadequate before reaching a 'good' rating at an inspection on 5 June 2019. Historic concerns were similar to those identified at this inspection, including missed visits, cancelled visits, excessively early/late visits and issues with staffing. The provider had given us assurances on the 22 January 2020 that measures were being taken to ensure adequate staffing arrangements were in place through agencies and that the management team was receiving appropriate support from senior staff. Despite these assurances, the findings of this inspection do not support that improvements were made in a timely way

Recruitment procedures had improved, and these were now safe.

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 13 August 2019).

Why we inspected

We received concerns in relation to staffing, missed visits and the management 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.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this report. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report

Follow up
We will request an action plan from 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 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Carewatch (Ipswich)

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
The inspection was carried out 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 and flats.

The service had a manager in place who had been in the role one and a half weeks when we visited. They had not yet begun the process of registering with the Care Quality Commission. When they do register, 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 a short notice announcement of this inspection on the morning of our visit. This was to ensure someone would be available in the office to assist the inspection.

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.

During the inspection-
Inspection activity began on 12 March 2020 and ended on 30 March 2020.

We made attempts to contact 29 people whose contact details we obtained from the service. We asked the

service to call them first to check that they were happy to speak with us. However, when we came to call these people, we were only able to get through to 11 of them despite several attempts. We also spoke with three external healthcare professionals.

We spoke with nine staff members including the manager, care coordinator, regional manager, a director of the company and care staff.

We looked at the care records for eight people using the service. We looked at a sample of staff recruitment files and records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.
We held a conference call with the provider to discuss how they intended to make improvements to the service. They told us that they had appointed an experienced area manager from within the company to directly oversee improvements within the branch.

Inadequate

Is the service safe?

Our findings

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

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 and systems and processes to safeguard people from the risk of abuse and learning lessons when things go wrong

- The service did not always take appropriate action to safeguard people.
- Records for one person indicated they had not received a care visit for ten consecutive days because their hearing aid was not working, and they could not hear the door to answer it to staff. The person was living with dementia and had poor eyesight. Carers had attempted to visit but had not been able to gain access. Risks associated with the persons' ability to independently answer the door had not been assessed. No consideration had been given to possible alternative methods for gaining entry, such as liaising with a neighbour who held a key. This placed the person at significant risk of harm and meant that for ten days the service did not know whether this person was safe and well. Whilst the carers did tell the office staff they were unable to gain access, no one in the office had raised concerns with a relevant organisation who could take appropriate action to keep the person safe.
- Once the ten days had passed, a carer was able to access the property and found there was no hot water or heating and that the person did not have any suitable food to eat.
- Care staff had also informed the office staff of a serious fire risk relating to one of the sockets in the property, a photo of which showed there was blackening around the holes the plug would fit into. This was also not escalated as a risk to other agencies.
- Care plans did not always set out in enough detail the ways in which people required support to reduce risks. This included reducing the risk of developing pressure ulcers.
- Healthcare professionals raised concerns with us about how staff identify and act on risks during visits. One person whose records we reviewed had their medicines locked in a case, with their agreement, as they were at risk of taking these incorrectly or in large doses due to their mental health. Their care plan clearly stated they must not know the code to the case and they had agreed they did not want to know. However, a healthcare professional told us that the person was aware of the code and one of the clasps on the case was broken. Staff had not identified this risk and raised it as a concern or safeguarding. The case contained large numbers of tablets and the healthcare professional was concerned about the risk this posed to the person.
- Concerns were raised by healthcare professionals that concerns they raised were not always listened to or acted upon them. One healthcare professional told us they had informed the office staff that a person using the service was upset and had refused care from a staff member who had a cough, as they were worried about the viral outbreak. They told us they then became aware a week later that this same staff member had still been visiting and the person using the service had been refusing personal care from them. This had led

to them developing sores which required input from nursing professionals. They were concerned this person had not been adequately protected during this time. Once they raised this concern with a different member of office staff, the carer was no longer sent to the person's home.

All of the above constituted a breach of regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always managed, administered and monitored safely.

● We reviewed the medicines administration records (MARs) which had been returned to the office from the homes of six people. Some of these MARs contained gaps which indicated people may not have received their medicines correctly. There was no evidence to demonstrate what had been done about this or that these omissions had been identified during auditing.

● One person was prescribed blood thinning medicine. This requires specific dosages to be given, sometimes different dosages each day, based on the most recent blood test the person had. If errors are made with doses of this medicine, it can cause blood clots or bleeding due to excessive thinning of the blood. The records we reviewed for this person demonstrated they had been given incorrect doses of this medication. This had not been identified and acted upon by the service, placing them at risk.

● After the inspection visit, a healthcare professional raised concerns with us about medicines administration for one person. They said they had looked at the person's medicines in their home and found the MAR charts recorded some refusals. They then found a rubber glove filled with discarded medicines which had been given to the person. The person was at risk of self-harming by taking too many of their medicines, so it was unsafe to have so many tablets available to the person at one time.

This constituted a breach of regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Our inspection was prompted by concerns about people not receiving their care visits as agreed. Evidence was provided to demonstrate that there were not enough staff to cover all the care visits to people. We shared these concerns with Suffolk County Council who telephoned a sample of the people they funded the care for, many of whom told them there had been issues with missed or significantly late/early visits.

● The provider told us in January 2020 that appropriate agency staff cover had been sought to ensure that people received their care visits as per their agreed care schedule. However, concerns were raised with us that these issues were continuing.

● At our visit to the office on 12 March 2020, we reviewed the log books for eight people using the service. These were only available up until 29 February 2020, as the logbooks for March 2020 were still in use in people's homes. These log books are where staff record their visits in when they arrive and leave people's homes. We compared these to the agreed care schedule set out in the records for these people.

● We found that despite assurances from the service in January and February 2020, significant issues with people's care visits continued up until the last date on 29 February 2020. These issues included people receiving care visits at varying times and not at the times they agreed they needed support from staff. The records were not comprehensive enough to enable us to determine whether people had always received care from two members of staff as per their care plan, or just one.

● The new manager told us that significant improvements had been made with visit times/missed visits and that would be evident in the log books for March 2020 which we could not yet see. They weren't able to provide any evidence to demonstrate this had improved, so we contacted people using the service to ask

about their experience of the service in March 2020.
● Out of the 11 people we spoke with, only two were happy with the service they received. The other nine people told us their service had not improved over the past two to three weeks and they still experienced visits which were either missed or not in line with their preferences. One person said, "They are not better of late. I had to wait an hour and a half for a call." One other person said, "I had a GP appointment, and these are important [for my mental health], I can't miss them. I called the office and said I must have my visit and it needs to be early. No one came, I had to call my [relative] for help, or I would have missed the appointment."

● Nine of the people we spoke with said that they got a rota on a weekly basis but that it was not accurate, and some days remained 'unallocated' so they didn't know who was coming to support them. One person said, "The person who came was different from the person on the roster. I did not know that person and they did not know me. I spent at least half an hour explaining what they needed to do for me. They did not have a clue how to care for me." Another person said, "The rota is a waste of time, I now put it in the bin, it starts on a Monday but never arrives until a Tuesday, but the names of staff who come are different to the names on the rota. It is not at all accurate."
● People told us they did not always feel safe when carers visited, because sometimes they were staff they did not know and had not been informed would be visiting. One person told us, "A carer turned up in the evening. This was an agency carer I did not know. It was dark when they turned up and it was a little frightening as I was not expecting them." Another person said, "I do not always feel safe. It is hard to have strangers come into your home."

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

● Our inspection was also prompted, in part, by concerns about safe recruitment practices.
● When we received these concerns in January 2020, we passed them on initially to Suffolk County Council who visited the service in February and looked into these. They told us that 12 staff members had to be removed from the rota because either safe recruitment checks had not been carried out, or staff did not have appropriate training. Some of these staff had positive disclosures on their criminal records checks but the manager had not risk assessed whether it was still safe and appropriate for these staff members to deliver care to vulnerable people.
● At our inspection visit we found that recruitment procedures had improved, and the service had carried out appropriate checks retrospectively for those carers who had been removed from the rotas. Some of those staff members had also left. We reviewed records relating to current recruitment procedures which were safe.

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.

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 and managers, staff being clear about their roles, and understanding quality performance, risks and regulatory requirements and promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- All the people we spoke with were positive about the carers who visited them. However, negative comments were made about the management of the service. One person said, "We don't have confidence in the management but can't fault the carers. I do not feel confident that the management would resolve issues. They over promise, and under deliver."
- People told us that the service did not always act on what they said or resolve their complaints. One person said, "I complained before to the office. They told me they would look into it, but no one came back to me, they never called me back. This was about one month ago." A relative told us, "I only raised complaints regarding missed and late calls. They say they will send a carer another day if a call was missed but they never do. Over the last three weeks, it dropped from an 8/10 service to a 4/10 service, so we asked the social services for another company."
- The service has been unable to sustain improvements that were found at our last inspection in June 2019. Prior to this inspection, the service had been rated inadequate in July 2018. Shortfalls identified at this inspection included there being insufficient staff to provide people with support, people having missed or cancelled visits or having visits which do not meet their preferences. These are similar to concerns we have found at previous inspections.
- Despite raising concerns with the provider as early as January 2020, reassurances provided about improvements to stabilise the service have not been demonstrated based on our discussions with people using the service, staff and the review of records.
- Senior staff in the organisation were not always responsive to our correspondence or correspondence from other organisations. For example, an email sent to a senior staff member had still not been responded to nine days after we requested information. A staff member from another organisation involved in monitoring the service's improvements told us the service had not responded to an email regarding progress on their action plan which was sent 14 days ago. This meant reassurances had not been provided about how improvements were continuing.
- The new manager of the service had started in the role a week and a half before our office visit on 12 March 2020. They had not previously had experience as a manager, and it was unclear how much support they were receiving. Although we were told they were having face to face support from another manager

every week, other staff told us this had not been happening.
● There were difficulties in completing the inspection in a timely way due to undue delays in the service providing information requested. This included during our office visit, where we had to make repeated requests for documentation.
● Things the manager told us were not always demonstrated by the evidence we found. For example, the manager told us there had been vast improvements in missed or late/early visits and that people using the service were happy. However, these improvements were not demonstrated in discussions with people receiving care from the service.

Continuous learning and improving care
● Whilst the service did have audit systems in place, it was clear these had not been consistently effective. For example, they had not independently identified shortfalls in recruitment prior to us sharing a concern with them. Shortfalls with medicines had not been identified through audit of log books, as not all of these had been audited. We were told by office staff there were issues with staff returning these log books to the office. This meant we were not assured these could be audited to identify potential shortfalls. One person using the service told us, "They never pick up the books they write in. I have them in the house from June, September, October 2019, and January and February 2020. Doesn't anyone need to look at these?"
● The provider had not identified that the previous manager was not performing adequately in their role and had not acted to address this until after we made them aware of concerns we received. This was despite this manager being in their probationary period. This meant we were not assured that provider oversight was effective.

Working in partnership with others
● External healthcare professionals we spoke with told us the service did not always act on what they said.

All of the above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12.— 1.Care and treatment must be provided in a safe way for service users. 2.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a.assessing the risks to the health and safety of service users of receiving the care or treatment; b.doing all that is reasonably practicable to mitigate any such risks; c.ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; g.the proper and safe management of medicines;

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 1.Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2.Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b. assess, monitor and mitigate the risks

relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 1.Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.