Careworld London Limited

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Inspection report

The Whitechapel Centre
85 Myrdle Street
London
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06 March 2019
07 March 2019

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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: Careworld London Limited is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older adults, younger disabled adults and children. At the time of the inspection the service was supporting 327 people in the London Boroughs of Hackney, Newham and Tower Hamlets.

People's experience of using this service:

● Poor practice and ineffective governance systems had resulted in people missing visits and receiving late care calls, which had not been followed up. One person said, "They come at different times and don't stay the full time. A lot of the time they don't turn up. I'm constantly having to chase it up and never get a call back."

● The service had ineffective systems in place to protect people from harm. The assessment of risk and medicines management across the organisation was inadequate. Advice and best practice guidance that we had shared with the provider at the previous inspection had been ignored.

● People were put at risk as the management team lacked clear oversight and knowledge of what was happening across the service. People continued to receive support from staff who had been suspended pending safeguarding investigations.

● The quality of care people received had deteriorated since the previous inspection.

● The culture of the service lacked openness, honesty and transparency. The management team were dishonest and provided inaccurate information, which placed people at harm as serious incidents were not acted upon.

● People and their relatives highlighted how the lack of communication impacted upon the service they received. One person said, "I call them and they never respond. It is now over a week since they were supposed to call and they haven't."

We found three continuing breaches of regulations in relation to safe care and treatment, good governance and notifiable incidents. We found two new breaches of regulations in relation to safeguarding people from abuse and improper treatment and failure to display their ratings. You can see what action we told the provider to take at the end of the full version of this report.

Rating at last inspection: At the last inspection the service was rated Requires Improvement. (Report published 9 October 2018).

Why we inspected: This was an unannounced focused inspection due to information of risk and concern we had received. At the previous inspection, we found breaches of three regulations and served two warning notices.

Enforcement: We have kept this service under review while we took action to cancel the providers registration as a result of breaches in regulations resulting in people receiving inadequate care.

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

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.

Careworld London Limited

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by anonymous information of concern received in February 2019 in relation to safeguarding concerns and quality issues. We shared this information with the local authorities who had also found a number of quality concerns during their own monitoring visits related to unsafe medicines management, missed visits and poor governance. We followed up these concerns during this inspection.

Inspection team: This consisted of three inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type: Careworld London Limited is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older people, younger disabled adults and children. At the time of the inspection the service was supporting 327 people in the London Boroughs of Hackney, Newham and Tower Hamlets. Not everyone using Careworld London Limited receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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: The inspection was unannounced. The provider was aware that we would be returning after the first day to complete our inspection.

Inspection activity started on 5 March and ended on 25 March 2019. We visited the office location on 5, 6 and 7 March 2019 to see the registered manager, office staff and to review care records and policies and

procedures.

What we did:
Before the inspection we reviewed the information the CQC held about the service. This included notifications of significant incidents reported to the CQC. We looked at the previous inspection report and the action plan the provider submitted after the previous inspection. We also spoke with the local authority safeguarding and commissioning teams and used their feedback to inform our planning.

During the inspection:
- We reviewed 21 people's care plans and medicines records
- 16 staff recruitment files
- Staff rotas and electronic call monitoring (ECM) data
- Complaints and safeguarding investigations
- Audits and records related to the management of the service
- We looked at a variety of policies and procedures developed and implemented by the provider
- We spoke with six staff members. This included the registered manager, the head of operations, the operations manager, the human resources manager and two care coordinators. We also spoke with an external consultant that had been recruited by the provider after the local authorities had highlighted concerns at their February 2019 visits
- We called 82 people using the service and managed to speak with 22 of them and 21 relatives

After the site visit, we contacted 60 care workers but only heard back from 11 of them. We also contacted seven health and social care professionals who worked with people using the service for their views and feedback.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely

- The service was not clear about its roles and responsibilities relating to medicines and there were inadequate systems in place to manage people's medicines. This meant that people did not receive their medicines safely.
- There were concerns at the previous inspection related to medicines and the provider told us they had reviewed their policies and procedures and care records had been reviewed. However, this had not been done and relevant national guidelines were not followed.
- Medicine administration records (MARs) were not accurately completed, with errors and gaps in recording that had not been followed up. We also found examples where people were supported with their medicines but there was no information included in their care plan and a risk assessment had not been completed.
- Health and social care professionals highlighted their concerns with how people's medicines were managed. One local authority raised five safeguarding alerts related to people's medicines during our inspection after carrying out further monitoring visits.
- People and their relatives highlighted the negative impact this had on the care they received. One person said, "My medicines are never on time and they are always late." A relative said, "There is no information and sometimes they don't even give them their medicines. I find pills on the counter and I don't know what or when they have been taken."

Assessing risk, safety monitoring and management

- At the previous inspection we found risk assessments lacked detail and important information about people's care. There were inconsistencies in the records we reviewed which did not always reflect the current level of care being provided. At this inspection we found improvements had not been made.
- We reviewed five care records where we found concerns at the previous inspection. Despite this being highlighted to the provider at the previous inspection, no action had been taken, which was acknowledged by the provider.
- One person was a smoker, who was supported with oxygen for a health condition. We had shared guidance from the London Fire Brigade as a matter of urgency. Despite this request, no action had been taken to mitigate the known risks to the person or the staff.
- One person said, "I have a regular carer who knows what needs to be done and knows what the risks are."
- However, we received a number of negative comments which highlighted the impact it had on the care people received. Comments included, "Half the time they don't read the care plan, they have no idea what the risks are" and "They don't assess risk. They don't use the hoist so my [family member] has to stay in bed. I am concerned about their welfare."

The above information demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Systems in place to prevent abuse were inadequate and placed people at unacceptable levels of risk. Safeguarding procedures were not followed to ensure that people were protected from abuse.
● We found nine examples where care workers had been suspended however electronic call monitoring (ECM) records confirmed they were still working during this period. This included allegations related to financial abuse, missed visits and neglect.
● We received mixed feedback from people and their relatives about how safe they felt using the service. One person said, "I feel totally safe. I have care four times a day and they help me in and out of bed." However, one relative told us that they had many concerns and did not feel comfortable leaving their family member alone. They added, "It is very unsafe. We stay with [family member] because we can't trust the carers to do what needs to be done."
● Where the provider had been made aware of serious allegations about staff members, there was no record that any action had been taken, which the provider acknowledged at the inspection. One member of staff had continued to carry out care visits in people's homes.
● At the previous inspection we found that safeguarding investigations were not always recorded accurately or were clear about the response to the concerns, with actions from safeguarding meetings not always being followed. At this inspection we found that improvements had not been made and safeguarding investigations remained disorganised and incomplete.

The above information demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Systems in place for reviewing incidents, accidents and complaints which occurred within the service were ineffective and did not support learning. Although concerns were discussed at care worker meetings, people and their relatives told us that these issues continued to occur and instructions had not been followed.
● One person said, "Every single care worker is not doing what they are supposed to be doing. They log in and put false times down and don't always stay the full visit and leave early. I complain but nothing has been done about it."
● Relatives told us even though they had complained about a number of issues, from small matters to more serious concerns, improvements had not been made. One relative added, "My [family member's] life depends on their care, they are elderly and frail and I don't think they are being treated very well."
● One care worker had been involved in a safeguarding investigation where they had acknowledged that they had falsified time sheets for calls they had not attended. There was no record of any disciplinary outcome and a supervision record two weeks after the investigation did not mention any of the safeguarding issues.

Staffing and recruitment
● Systems in place were ineffective to ensure people's needs were met and calls were not being monitored to make sure people had their visits on time. Samples of rotas had insufficient travel time between calls and issues with inaccurate ECM records had not been followed up.
● The majority of feedback we received from people and their relatives highlighted the negative impact missed and late calls had on their health and wellbeing.
● One person said, "I am meant to have a morning and afternoon call and mostly I get morning only and that is late. I don't know if they stay the full visit or not as they rush in and rush out." One relative said, "My real concern is that the carer is so often late, almost two hours, my [family member] can't have breakfast

until they've been. This visit is then accomplished in 15 minutes which is incredibly rushed." Another relative explained how visit times were so erratic it increased the risk to their family member's health as they were diabetic and morning calls had been as late as 11.45am. A third relative told us how calls were missed and they were not given an explanation about why.

● We were so concerned about one person after speaking with their relative about missed calls and the risks it created, we contacted the provider and relevant local authority on 8 March 2019 to make them aware and ensure enhanced monitoring was in place to confirm their upcoming weekend calls were attended.

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

Preventing and controlling infection

● Infection control assessments were completed at the start of people using the service during the initial assessment.

● People and their relatives did not raise any issues or concerns with us regarding the prevention and control of infection.

● Care workers we spoke with confirmed they had access to personal protective equipment (PPE). One care worker said, "There is always enough PPE. I get it from the office at least every two weeks when I hand in my timesheets."

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- At our previous inspection, we found that we had not been notified about significant incidents that had happened across the service. Providers must notify CQC of particular incidents that affect the health, safety and welfare of people who use services. At this inspection we found that improvements had not been made, despite the provider submitting an action plan to explain how these issues would be addressed.
- Safeguarding concerns that had not been notified to us included allegations of neglect, financial abuse and falsification of records by care workers. They also included alerts raised by the London Ambulance Service and hospital discharge teams.
- The provider acknowledged during feedback at the inspection that regulatory requirements related to warning notices and previous breaches had not been met and improvements had not been made.
- Before the inspection we asked the provider to carry out an investigation into allegations of falsified documents as a matter of priority. However, this had not been done. The head of operations said, "The company has grown and the challenges we have faced are overwhelming. We feel we are unable to prioritise at the moment."
- The provider was failing to display their current rating at the time of the inspection. A copy of their updated rating of Requires Improvement from their previous inspection was located in the office, however their website had not been updated to highlight this change. This had been discussed at their previous inspection.

The above information in relation to notifiable incidents demonstrates a continuing breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

The above information in relation to the display of ratings demonstrates a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- There were ineffective systems in place to monitor and review the service against best practice guidance. The provider had a lack of oversight of the organisation as a whole which meant that serious concerns and issues were not identified or addressed.
- We found evidence that documents had been falsified whilst completing audits, which the provider acknowledged. This meant that we could not be assured about the credibility of information and documents we were provided with.
- We found serious concerns and allegations about missed visits and incidents where two care workers

were failing to attend double handed calls had not been followed up. Timesheets which showed care workers not attending calls at the same time had not been checked. Care workers told us how the second care worker being late had a negative impact on the service. One care worker said, "I've reported my double up not attending the call but there has been no follow up."

● We saw correspondence from health and social care professionals who had found concerns with the service provided, where they had previously been given inaccurate information from the provider.

● We requested further information from the provider immediately after the inspection. There was conflicting information and local authorities confirmed they had found a number of discrepancies with the information provided. This meant the provider did not have accurate records relating to the care and support that people received.

The above information demonstrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● The provider did not promote an open and transparent culture across the service. Throughout the inspection we were given false, dishonest and misleading information, with evidence of falsified documents in place. This put people at an unacceptable level of risk.

● After the previous inspection we asked the provider to submit monthly reports, which included any missed visits across the service. Reports from October 2018 to January 2019 all highlighted there had been no missed visits, however this is not what we found at the inspection. The provider acknowledged that the information within the reports was not true and they had been dishonest.

● We followed up information of concern that had been given to us prior to the inspection. Serious allegations we had been made aware of were originally denied by the senior management team. However, on the second day of the inspection, a member of the senior management team acknowledged that they had been made aware of this information but had not taken any action.

● There were consistent themes across the service of allegations related to falsified time sheets and care workers not staying for the full visit.

● We received mixed feedback from people and their relatives about how well managed the service was. One person said, "I feel it is well managed. I am very satisfied." However, negative comments included, "I don't think they listen or even care, they are very unreliable" and "My carers are excellent but the office staff are totally unreliable and I'm not happy at all."

● One relative told us when they raised a concern, the office told them to call social services instead. They added, "I was shocked by this and basically, I don't feel I can talk to them."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We received mixed feedback from people and their relatives on whether they were asked for their views about the service. One relative said, "Since we told them about an issue with the carer, things have improved greatly."

● However, we received numerous comments about the lack of communication from the office. One person said, "I am constantly having to chase them up and they never call me back. It isn't good. One relative said, "I don't get any feedback about lateness or changes. It makes me feel as though I'm not important."

● We also received mixed feedback from staff about the support they received. One care worker said, "They are very good at listening to you. They do their best to sort the situation and any concerns they call you back."

● Care workers told us the regular change with office staff caused communication issues across the service.

Comments included, "They don't communicate well and information doesn't get passed onto clients" and "The lack of communication from the office makes our life a little bit harder." One care worker told us that they never heard any response from management when they raised concerns, which was extremely frustrating. The head of operations told us their diverse workforce could create a difficult office culture.

Working in partnership with others

● We saw the provider had worked in partnership with a range of health and social care professionals to support people's care needs. However, local authorities had found a number of concerns across the service. The provider acknowledged that information previously shared with local authorities had not always been an honest reflection of the service.

● The provider had recruited a consultant in response to the concerns that local authorities had found prior to our inspection. The provider acknowledged all of the findings from our inspection.

● The two main local authorities placed formal suspensions on the provider following our inspection and were meeting them on a weekly basis to review the service.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18(1),(2) (a) (ii) (iii) (b) (e) (f)

The enforcement action we took:

We served a notice of proposal to cancel their registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that risks to the health and safety of service users were regularly assessed and did not do all that was practicable to mitigate any such risks. Regulation 12(1)(2)(a),(b) The provider did not ensure that care and treatment was provided in a safe way as systems for the proper and safe management of medicines were not operated effectively. Regulation 12(1),(2)(g)

The enforcement action we took:

We served a notice of proposal to cancel their registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect service users from abuse and improper treatment. Systems and processes were not established to prevent abuse. The provider was failing to investigate allegations or evidence of abuse in a timely and appropriate manner.

	Regulation 13(1)(2)(3)

The enforcement action we took:

We served a notice of proposal to cancel their registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure systems or processes were in place to assess, monitor and mitigate risks relating to the health, safety and welfare of service users. The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided. Regulation 17(2)(b)(c)

The enforcement action we took:

We served a notice of proposal to cancel their registration.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered provider failed to display their rating of performance by the Commission following an assessment of its performance. Regulation 20A(1)(2)(a)(b)(c)

The enforcement action we took:

We served a notice of proposal to cancel their registration.