Community Care Worker Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Community Care Worker Limited is a domiciliary care service supporting people with personal care in their own homes. The service was supporting 58 people at the time of our inspection. Younger and older people had support needs such as physical and sensory impairments, learning disabilities, dementia or mental health needs. 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
Systems to monitor the and improve the quality of care had improved, however, these were still not fully effective at identifying all concerns and had not fully embedded into custom and practice.
Medicines management required improvement to ensure people's medicines were always safely managed. Risks to people were not always assessed and planned for, although improvements were made following our feedback. Lessons were learned when things went wrong, although systems required strengthening to ensure all issues were identified. Staff were recruited safely, although checks could be more robust.

People were protected from the risk of abuse by staff who understood their responsibilities and knew to report concerns; appropriate referrals had been made. People were protected from cross infection as staff used appropriate personal protective equipment. People were supported by enough staff.

People had access to other health professionals when necessary. People's health conditions were recorded in their plans. Staff received training to be effective in their role and felt supported. People were appropriately supported with their food and drinks. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Documentation required strengthening to ensure it was clear why people were not signing their own consent to their care and support.

People were supported by a kind and caring staff team. People's dignity was maintained, and they were supported to remain as independent as possible. People's protected characteristics were taken into account and people were involved in decisions about their care.

No one was being supported with end of life care, but action was being taken to ensure the service was able to effectively support people should the time come. People had personalised care plans in place and were supported in a way they liked. People felt confident and well supported by their regular staff. People were supported to communicate in a way that suited them. People and relatives felt able to raise concerns and these were investigated and responded to.

The previous rating was being displayed and notifications were submitted as required. People were asked their opinion about the service and people had given positive feedback. Staff had their competency checked

and the service was on a learning and improvement journey with the support of an external consultant. Staff felt supported by management. The provider and care manager were aware of their responsibilities regarding duty of candour. The service worked in partnership with other organisations and there were future plans to expand this.

Rating at last inspection
The last rating for this service was requires improvement overall, with inadequate in well-led (9 July 2019). There was previously a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to poor oversight of the service and a failure to improve enough following previous inspections. At this inspection we found the service was no longer in breach.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we 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 effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Community Care Worker 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. 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 one inspector and one assistant inspector. There was also an Expert by Experience who supported the inspection making phone calls. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Community Care Worker Limited is a domiciliary care agency. It provides personal care to people living in their own homes.

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. The registered manager and the provider were the same person, we refer to them as the provider throughout this report. Another manager was also in the process of applying to become registered with us, who we refer to as the care manager within the report.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to gain people's consent to accept phone calls and visits from us. Inspection activity started on 8 January 2020 and ended on 17 January 2020. We visited the office location on both of those dates and made phone calls and visits to people between them.

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 looked at the information we held about the service, such as the notifications submitted to us. Notifications are events the provider has to tell us about by law, such as deaths, serious injuries or safeguarding allegations. We asked the local authority and Healthwatch if they had any information to share with us about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and four relatives about their experience of the care provided. This included a visit to one person's home who was being supported by Community Care Worker. We spoke with nine members of care staff including some senior care staff. We spoke with the provider who was also the registered manager, the care manager and the external consultant employed to support the service.

We reviewed a range of records. This included six people's care records and multiple medication records. We reviewed three staff recruitment files. We looked at a variety of records relating to the management of the service, including audits, complaints and safeguarding records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also looked at rotas, updated care plans and training data.

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 requires improvement. At this inspection this key question has remained the same. 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.

Assessing risk, safety monitoring and management

- Risks to people's health and wellbeing were not always assessed and planned for.
- One person had a health condition with physical symptoms that would indicate when they were unwell. They could also experience agitation and distress. Although the records identified the health condition, there was no additional guidance for staff to describe how they should respond to any physical symptoms or how to support them during times of agitation. Staff gave differing responses as to how they would respond if the person became unwell. This meant there was a risk the person may be supported inconsistently and not always have their symptoms acted upon appropriately.
- Following our feedback, the provider took immediate action to seek additional medical advice and put a plan in place.
- Another person was noted as being at high risk of falls but there was no detail as to how this had been arrived at, and no subsequent plan or assessment to support the person in relation to falls. This meant there was a risk they could be supported inconsistently. Following our feedback, a re-assessment was carried out
- Despite this, people told us they felt safe whilst being supported by staff. One person said, "Oh yes [I feel safe], it's the fact they [staff] are there and the banter and checking I'm alright." A relative said their relative's mobility changed and they sometimes needed to use a frame, they explained staff supported the person correctly, "My relative had their frame out again. If it's there, they [staff] know to use it."

Using medicines safely

- Medicines were not always managed safely.
- Some people had medicine on an 'as required' basis, also known as PRN medicine. Whilst there was instruction as to where topical medicines needed to be applied, there was not always detail about how staff would recognise it was needed or the maximum dosage per day in some cases. This placed people at risk of not receiving their prescribed medicine, or having too much, or too little medicine applied. Following our feedback, action was taken to put these instructions in place.
- One person was being supported to have a medicine patch applied to their skin. The manufacturer's instructions stated it should not to be positioned in the same place for three to four weeks, as it could cause skin irritation or thinning of the skin. There was no record of where this was being applied, so there was a risk it may be applied in the same or similar place. The Medication Administration Records (MARs) also did not describe when each patch was removed. Therefore, there was a risk of more than one patch being applied at the same time. Following our feedback immediate action was taken to put records in place for staff to record where the patch was being applied.
- Staff told us, and we saw that MARs had improved since our last inspection. However, there were some gaps in records that were not always explained in the care notes, so we could not be sure people were

always offered their medicine when needed. This meant there was a risk some people may not always be getting their medicines when prescribed. Despite this, people ad relatives told us they were supported appropriately with their medicines. Staff knew to highlight and report concerns, however we could not be sure this was always happening.

Learning lessons when things go wrong

● Lessons were learned when things went wrong, although checks on unexplained gaps in medicine records required strengthening to ensure all errors would be identified and investigated.

● Accidents, incidents and known medicines errors were reviewed to ensure appropriate action had been taken and the frequency of incidents such as falls was reviewed. One staff member said, "I know how to use that [MARs] and what to fill in. I got pulled up once on it as I made a mistake, I left it blank, but I've got a routine now."

Staffing and recruitment

● People told us staff were generally on time to calls. One relative said, "99% of the time they are on time."

● Staff told us there were enough staff and they weren't expected to 'call cram' (be in two calls at the same time) and that their rotas were generally manageable. People who needed two staff to support them, had two staff visit them at the same time.

● The rotas had recently been made more stable, although people had experienced some changes as a result of this. Staff generally had set rotas so they often saw the same people. There was a monitoring system in place for staff to log in and out of calls, so punctuality and calls durations could be monitored.

● Staff were recruited safely, although checks could be more robust. Checks on staff member's suitability to work with people who used the service, such as criminal record checks, identity and references were made. However, there was not always a full employment history and some references were not clear if they were provided by the most appropriate person.

Systems and processes to safeguard people from the risk of abuse

At the last inspection, people were not always protected from the risk of abuse. At this inspection, we found improvements had been made.

● People were protected from the risk of abuse and told us they felt safe.

● Staff understood their safeguarding responsibilities, could recognise different types of abuse and knew to report their concerns to the designated safeguarding officers in the company or they could go to the local safeguarding authority.

● Appropriate referrals were being made to the local safeguarding authority to help keep people safe.

Preventing and controlling infection

● People were protected from the risk of cross infection. People told us staff wear aprons and gloves when needed and staff were able to tell us the appropriate times when they should be worn and changed.

Good

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 requires improvement. At this inspection this key question has improved to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

- People said they were asked for consent prior to being supported. One person said, "They always tell me what they are doing and ask permission."
- However, we found in some instances care plans relatives had signed agreement to care and the reason for this, and the person's instruction to have relative's sign on their behalf, had not been recorded. When someone did not have capacity to consent to their care, we saw the relative or appropriate person's right to consent on a person's behalf had been verified. This is called Lasting Power of Attorney.
- Staff had a good understanding of what capacity meant and how to support people to make choices.
- The provider was aware of their responsibility to assess people's capacity.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People had access to other health professionals when needed. One person gave us an example where staff had contacted emergency services on their behalf as they were concerned about their well-being.
- People's health conditions were specified in their care plans.
- The provider often supported people who were referred to them by the local authority. An initial care plan was sent to the provider to ensure they could meet a person's needs. A visit to the person would then mean a face to face assessment would be carried out, taking into account people's needs and their home environment.
- Nationally-accepted best practice tools for assessing people's health conditions, such as skin integrity, were being introduced to ensure these were monitored. Skin inspection charts were also in place, so concerns could be regularly recorded and to show what action had been taken to protect people, if

necessary.

Staff support: induction, training, skills and experience

● Staff received training and support to be effective in their role and received an induction when they first started. One staff member said, "I had a lot of training on the beginning and I've been out to meet people." People and staff confirmed that new staff shadowed more experienced staff to assist in getting to know people and become more confident.

● Training in relation to specific health condition was put in place following our feedback and in conjunction with the person who had the health condition, so all staff knew how to respond to concerns.

● Staff were being supported to complete the Care Certificate, which is a nationally recognised scheme to ensure staff all have consistent knowledge to work in the care sector.

● A more structured approach to supervisions had been introduced to ensure all staff were given regular opportunity to discuss how they were getting on and any support needs. A plan had been put in place for the rest of 2020 to ensure these were completed and all staff had at least four supervisions a year.

● People told us they felt staff knew what they were doing; staff who were visiting someone for the first time may need more direction but regular staff knew people's routines which made people feel more confident in their ability.

● Staff training was being more effectively monitored to ensure staff had it in place and remained up to date. This was an improvement since the last inspection as staff training was not always being effectively monitored.

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

● People often assisted themselves with food and drinks, however those who required support told us they received this as necessary. People told us they were offered options and could tell staff what they wanted.

● Details of whether people needed support, and how, were in people's care plans to guide staff.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has improved to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us they were well treated and supported by staff. One person said, "They [staff] are always very polite and helpful." Other comments included, "They [staff] are all nice and caring" and, "I'm very happy with the care."
- A relative told us, "The individuals [staff] they seem to hire appear to be caring and capable. No one is miserable, and they want to be helpful."
- People diverse needs were recorded in their care plan. Some people or their relatives had English as their second language, where possible staff who could also speak the same first language were able to support the person. People were supported with their religion.

Supporting people to express their views and be involved in making decisions about their care

- People were supported to be involved in decisions about their care. People confirmed they were offered choices and their consent sought, prior to being supported.

Respecting and promoting people's privacy, dignity and independence

- People confirmed they were treated with dignity and given privacy. One person said, "The carers are all lovely people and are always respectful." Another person told us, "Oh yes, I'm definitely treated with dignity. The very fact of how we get on. None of them make me feel embarrassed."
- People confirmed they were supported to remain independent. Staff were all able to give us examples of how they supported people to maintain their dignity and independence. One staff member said, "I close curtains so no one can see, leave people in the toilet, if they can be left – they shout when they're ready. You let them do as much care for themselves as possible."
- People's paper care records were stored securely to ensure only those who were entitled to access them could, to ensure people's privacy was maintained.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has improved to good. This meant people's needs were met through good organisation and delivery.

End of life care and support

● No one was receiving end of life care at the time of the inspection. People did not always have their end of life wishes recorded in a plan, however we saw steps had already been taken to improve in this area. Additional training was being implemented and an information pack had been put together.

● The provider was aware of their responsibilities to liaise with other agencies and professionals to support people, such as GPs, social workers and occupational therapists.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People were supported in a way they liked and generally had regular staff. One person said, "They [staff] are good at everything I ask them to do. They [staff] do a very good wash. It is done to a good standard." Another person explained, "I generally see the same staff, same staff on the evening and mornings for a couple of weeks, perhaps they'll change. I'm really glad when it is them [regular staff] and they are very efficient without rushing me."

● Recently the rotas had been changed so they were 'templated', this meant staff were put on set calls, so coordinators did not have to cover calls each week. The external consultant had supported this to be put in place as it had not been done by the service before. Some people had noticed a change and experienced a variation in staff due to this, however, people generally saw a regular staff team to support them.

● People had care plans in place which detailed their preferences, so staff knew how people liked to be supported. These were reviewed; one person said, "I have a file here and they come out and review it from time to time."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People were supported to access information in an appropriate way for their needs. For example, one person used a non-verbal way of communicating. We were told staff had been taught some basic methods of communicating with the person and their family were also able to support with this. Another person used technology to communicate, which was catered for.

● Those who had English as their second language were also supported by staff who spoke the same language, where possible.

● The provider explained they would offer plans in alternative formats if required.

Improving care quality in response to complaints or concerns

● People and relatives felt able to raise concerns if they needed to. One person said, "I'd ring the office, yes they are approachable. It's a rare occurrence to call." Another person told us, "I'm the type of person that can talk to most people. I can ring the office. They do listen. I will keep calling until they do."

● When a complaint had been made, concerns were investigated, action taken and a response sent to the complainant.

● There was a new quarterly review of the trends for complaints, but as this had only recently been introduced, there was not much data to analyse.

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 inadequate. At this inspection this key question has improved 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection the provider had failed to ensure quality assurance systems were effective at monitoring and improving the quality of care to people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, enough improvement had been made so the service was no longer in breach, however we needed to be assured improvements would be sustained and all quality assurance systems would become embedded.

- Systems had been put in place to monitor the service. Whilst these were an improvement on previous methods of quality assurance, some improvements were still needed and systems needed to be embedded to ensure people always received safe care.
- The lack of oversight of, and personalised plan for, a person's specific health condition had not been recognised through audits. Staff were recording episodes of the person experiencing symptoms of their health condition and this had not prompted further scrutiny following notes being audited.
- Audits on MARs were not always effective at checking whether people always received their prescribed medicine when it was required. MAR charts were not consistently used by staff, as staff did not always record whether people had taken their prescribed medicine. The audit of these records did not show how these omissions in records had been investigated, to ensure lessons were learnt.
- One person's prescription label instructions differed to the instructions on the MAR. This had not been identified and investigated through audits.
- There was improved oversights of accidents, incidents, medicine errors and spot checks on care staff. This was the start of a more coordinated approach of monitoring the service as a whole and identifying trends. However, this had not been in place long enough for us to assure ourselves it was now common practice and would be sustained.
- Whilst there were improved systems, being as all concerns were not fully identified through audits, we could not be sure the overall analysis of concerns contained all the necessary information to identify trends and what action may be needed.
- An electronic system was being used to record all communication within the service, so it could be tracked and more easily found, as things had previously been recorded on paper.
- Regulatory requirements were being met. The previous rating was being displayed and notifications were submitted as necessary.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● People were engaged and asked for their opinion about the service. Surveys were being carried out with plans to increase the amount of surveys per year. One person said, "I think there is at least one or two surveys a year." Another person said, "Yes they have done; I've done two in 12 months." Responses were positive and people were generally very satisfied with the support they received.

● Staff had their competency checked to ensure they were effective in their role and continuously learning. One staff member said, "Yes, [I get spot checked] every three months. They check my apron, gloves, that I'm doing the right things and checked the medicines."

● There were also regular senior staff meetings to discuss progress, outstanding actions and keep a record of what had been completed. This meant it was easier to track improvements and see what else needed doing.

● The provider had engaged support from an external consultant with experience with domiciliary care to help them improve and learn. They were supporting them to develop a communication plan to ensure all people, relatives, staff and external professionals were effectively engaged with the service.

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

● People felt positively about the management team. People often knew who the provider was and felt they were approachable. One person told us they had a very positive relationship with the provider and had friendly 'banter' with them. A relative said, "[The provider] keeps us up to date. I pop into the office for a drink."

● Staff consistently felt positive about the provider and management team and felt supported. One staff member said, "Management is good, always there if you need them, I can always approach them. I feel supported, if I have any questions they always help me by answering questions."

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

● Systems were being developed which monitored the service more closely and to ensure concerns were identified and improvements made. When things that had gone wrong were identified, these were reviewed. The provider and care manager understood duty of candour and the need to be open and honest.

Working in partnership with others

● The service worked in partnership with other organisations, such as health services and an external consultant who was supporting the service to improve.

● There were further plans to engage with the local community and develop social opportunities for people.