SVK Care Ltd

Caremark Hinckley Bosworth & Blaby

Inspection report

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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 Hinckley, Bosworth & Blaby is a domiciliary care agency which provides care and support to people living in their own homes. At the time of our inspection the service was supporting 108 people, 88 of those people were in receipt of 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
Risks associated with people's care were not always identified and recorded. Care plans did not always contain current and consistent information about people's health needs.

Not all staff were recruited safely, and the deployment of staff was not always effective at meeting the needs of the people they supported.

The systems and processes to review care records and oversee the use of medicines was not effective.

We heard from people, their relatives and staff that calls were often delayed or cut short. Systems and processes in place to review call information, and to receive feedback from people, were not effective as they had not identified these concerns.

People, their relatives and staff gave mixed feedback about the leadership and the management of the office.

The registered manager had a good understanding of the duty of candour and they had a policy in place for this. The duty of candour is their legal responsibility to be open and honest with people when something goes wrong.

People and their relatives told us that they felt safe when receiving care.

Staff understood how to keep people safe and had received training in this.

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 26 June 2021).

Why we inspected
We received concerns in relation to staffing, missed calls, infection prevention and control measures and recruitment. As a result, we undertook a focused inspection to review the key questions of safe and well-led

only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. 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 Hinckley Bosworth & Blaby 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 and will take further action if needed.

We have identified breaches in relation to the safe care and treatment of people, leadership and governance and recruitment of care staff at this inspection.

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

We sent the provider a warning notice asking them to make changes. When we next return to inspect the service, we will consider what improvements have been made.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 Hinckley Bosworth & Blaby

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 Health and Social Care Act 2008.

Inspection team
Two inspectors attended both days on site, and both inspectors made calls to staff in the following days, as part of the inspection. Two Experts by Experience supported with calls to people who use the service and their family members. 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
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 23 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on Tuesday 15 March 2022 and ended on Friday 25 March 2022. We visited the location's office/service on Tuesday 15 and Wednesday 16 March 2022.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 15 people who use the service, and 12 relatives. We also spoke with 12 staff including the director, registered manager and 10 care workers.

We reviewed a range of records. This included 10 care records, and 10 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We looked at daily records and a care plan for a further person. 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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- Where MAR charts were in place, they were not always up to date with prescribed medicines for each person and did not detail the correct level of support people needed. One staff member told us, "I always ask the clients, I don't go off what is on [the electronic records] – it changes. I go off what they want not what is on [the electronic record]." This lack of up to date information regarding medicines on MAR charts put people using the service at risk of ill health as medicine may be given incorrectly.
- People who needed 'as required' medication did not always have sufficient guidance for staff on how to administer this. For one person who was in hospital at the time, the protocol which had been used was poor quality and did not contain enough information to guide staff about gaps between the medication. This had placed this person at risk of overdose of the medicine as the guidance provided was not clear.
- Care staff did not always follow the provider's medication policy. For example; the policy stated that 'We will never: Purchase, prompt, assist or administer any 'over the counter' medication without authorisation from a health care professional'. However, care staff documented that they were applying 'over the counter' creams which had not been prescribed by a healthcare professional.
- People reported that the fluctuation in times of care calls had an impact on when they receive their medication. Some care calls were very early, and others were very late. This puts people at risk of overdose with medication due to the required gap between doses potentially being long enough.
- Staff told us, and the training record showed care workers receive regular training in medicines.

Preventing and controlling infection

- We were not assured staff were using personal protective equipment (PPE) effectively and safely in accordance with government guidance. One person told us staff do not wear face masks at all their care visits. Some staff also told us they do not wear face masks at all care visits. The provider had made some attempts to communicate the need for staff to wear PPE, however the lack of compliance of staff put people at increased risk of COVID-19 transmission.
- We were not assured all staff were accessing testing. One staff member told us they were not completing lateral flow COVID-19 testing at the required frequency. When we spoke with the registered manager, they showed us they had made efforts to make staff aware of the importance of testing and wearing masks, but this was ineffective as staff were not following government guidance.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Care plans did not always reflect people's current needs and there was a lack of clear guidance for staff on how to manage people's conditions safely. For example, one person's care plan stated they had been diagnosed with dementia. However, there was no further reference to this in the care plan, or any guidance

for staff on how to support the person to manage their condition.
● Staff told us people's care plans lacked essential information. One staff member told us, "They [the office] need to put into each person their medical history, so more carers can see what is wrong with each person, we rely on each other to tell each other what they have got." This put people at risk of not receiving safe and consistent care and support.

The provider did not always provide safe care and treatment to people using the service. Risks were not always managed; medicines were not managed safely, and shortfalls in infection control practices and use of PPE by staff put people at risk of COVID-19 transmission. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks associated with people's care were not always identified and recorded. Where people lived with diabetes, there was limited guidance for staff to enable them to recognise potential risks and signs of deterioration. For example, if blood sugar levels were too high or too low. We highlighted our findings to the registered manager and risk assessments were put in place.

Staffing and recruitment
● Staff were not always recruited safely. The provider's recruitment policy stated they should, 'Obtain at least two satisfactory references, and check gaps in employment history.' We reviewed 10 staff files and found not all had two references or full employment histories.
● One staff member had no references in their record at all and another had professional references, but they had not included the dates of employment.
● This is not in line with the provider's recruitment policy and meant there was a risk people were being supported by staff who may not be suitable.

The provider did not implement robust recruitment processes. This put people at risk of harm by being supported by staff that were not suitable. This is a breach of Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not effectively deploy staff to meet the needs of the people they supported. We spoke to 15 people and 12 relatives. Of these 27, 13 reported late calls, issues with staffing or not knowing which staff member would attend. Staff told us morning calls can run up to one o'clock in the afternoon, and sometimes management ask them to attend visits that require two staff members on their own. This meant people may be put at harm from calls that are not timely or where people were not supported by sufficient staff numbers to care for them safely.
● All staff had undertaken a satisfactory Disclosure and Barring Service (DBS) check. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt safe when receiving care. Feedback from people was positive about the care provided to them. One person told us, "I feel safe – very much so with the carers. They really understand what I'm going through. The staff – even the new ones learn very quickly. Very good."
● Staff understood abuse, and the forms which it can take. Staff told us they had received training and felt confident reporting safeguarding issues to the management team.
● We saw evidence safeguarding issues had been reported to the local safeguarding team, and notifications had been submitted to the Care Quality Commission.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- Oversight of records relating to the care and treatment of people using the service was not sufficient. The provider's own checks had not identified records were not all up to date with information and neither did they all provide enough guidance on how to respond to risk. This put people at risk of care that was not safe.
- Audits and checks of medicines did not identify the shortfalls that we identified on inspection. It had not been identified in line with NICE guidance, staff should have a check on their competency for medicines every year and all medicines where prompting occurred should be recorded. This lack of oversight put people at risk of receiving medicines in a way that was not safe and appropriate for them.

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

- Adequate systems for monitoring call times were not in place. The provider failed to monitor calls to people to ensure staff arrived on time and stayed for the required time. One relative told us, "I have complained about the times of (relative's) visit. They've taken it on board, but nothing has happened". Another relative told us, "I go directly to the office, they are easy to talk to, but it falls on deaf ears because of the lack of carers." As the provider had no oversight of the timeliness of care calls, opportunities to make improvements to the quality of care people received were missed.
- People did not always receive person centred care. People and their relatives told us the importance of the timings of the calls delivered. There was a lack of systems and processes in place to ensure people were reliably informed about changes to their care workers. One person said, "I never know when they are coming," and another said, "They don't let me know if they are running late, they just turn up."
- We received mixed views from staff about the leadership of the service. Whilst some care workers felt the registered manager was a responsive leader, several others told us they felt unsupported and that the office support felt disorganised. One care worker told us, "The support for the staff isn't good." We heard from the leadership they provided support for their care workers, for example adding a care worker to the company car policy so the care worker would be able to work and earn when their car broke down.
- People and their relatives reported mixed views about the registered manager. One person told us, "They (the manager) don't really listen to me." Whilst another person told us, "I do know the manager and (they) listen to me."
- People and their relatives gave mixed feedback about the contact they received from the office. One person told us, "They don't let me know if they are running late they just turn up," whilst one other person who uses the service told us, "The office always lets me know (if they are late)."

● Staff did not receive annual reviews, regular supervision, or regular spot checks. This meant opportunities to discuss priorities such as COVID-19 and PPE training including infection control, high-risk health and risk assessments were missed.

We found no evidence that people had been harmed however, the quality monitoring system did not effectively identify and address people's concerns regarding calls not happening at the agreed times and lasting the full duration. The systems and processes to review care records and oversee the use of medicines was also not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were generally happy with the care they received from the staff. One person told us about the care workers, "I'm comfortable with them. They're the best thing since sliced bread." Another person said, "Care is second to none. Fantastic."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Management did not engage sufficiently with staff and involve them in the running of the service. The impact was issues which had arisen and other information necessary for staff to undertake their roles were not communicated sufficiently by the registered manager. The registered manager recorded a message for the staff in place of one meeting as no staff had attended, which was shared with staff to review in their own time. This meant staff were not always involved in a conversation about changes to practice which may have impacted upon how they cared for people.
● People and relatives gave us mixed feedback that they were asked their views, and some reported receiving a questionnaire. We saw no evidence that the provider had tried to capture people's views in other ways.
● We saw evidence that the service worked in partnership with other professionals. For example, they included advice from professionals into the risk assessments they produced.

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
● The provider understood the underpinning principles of the duty of candour and had an appropriate policy and procedure in place.
● Staff gave honest information and suitable support and knew how to apply duty of candour where appropriate.
● Our records showed that appropriate notifications were made to the Care Quality Commission as required.

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 Safe care and treatment was not always provided at the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Care workers were not always recruited safely.

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 17 HSCA RA Regulations 2014 Good governance The inspection found governance systems were not robust and placed service users at risk of unsafe care.

The enforcement action we took:

Issued a warning notice