RochCare (UK) Ltd

Community Careline Services

Inspection report

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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

Community Careline Services (CCS) is a domiciliary care agency providing personal care to people in their own homes. At the time of the inspection they were supporting 41 people across the borough of Rochdale.

People's experience of using this service and what we found
Most people we spoke with told us that their experience of the service was poor. People had not always received their care and some care visits had been excessively delayed. Family members told us that they had been asked to step in to look after their relatives. We had received concerns prior to the inspection and several packages of care were returned back to the local authority as people could not be cared for safely.

Staffing levels were low and existing staff felt undervalued and pressured to work long hours. People were concerned about the stress the carers were under and did not feel they were at fault in any way. We were made aware that the previous registered manager and several staff had left the service in April. The service had deteriorated since then and recruitment had been limited. Staff that had been recruited, had been recruited in a safe manner.

Communication was poor at the service and both service users and staff told us how difficult it was to contact the office and on call system. Rotas were chaotic and there was no designated person responsible for ensuring the visits were covered. Missed visits and duplications in the rotas were not picked up by the current system. Following on from inspection the provider ensured that a care coordinator had overall responsibility for the management of rotas.

Medication was not being managed safely. People were not receiving their medication at the specific times that they needed them and there were concerns around administration.

The service was moving to new electronic care plan system, but this had not yet been fully implemented. Some care plans we saw did not always reflect people's needs fully and there were discrepancies around what hours were actually being provided.

We identified a lack of oversight of the service and there was no monitoring of the quality of care people were receiving. There were no audits or spot checks taking place at the service and people were not being consulted about their views on the service.

Infection control was being managed safely. Staff wore appropriate PPE and followed government guidelines around infection control and testing.

The service had a new manager in post, who was not available at the time of the inspection.
Feedback we received about the new manager was positive and we saw evidence that some concerns had

been addressed. Following on from inspection, the manager and the area manager sent us an immediate action plan addressing the issues we found on inspection and this was also shared with the local authority. We had a meeting with the provider following on from the inspection who informed us that the area manager had left their post and they had recruited a new area manager, as part of a restructure of the company.

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 21 June 2018)

Why we inspected
We received concerns in relation to concerns around the management of the service and staffing levels. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Community careline 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 have identified breaches in relation to medication, staffing, safe care and treatment and good governance at this inspection.
Please see the action we have told the provider to take at the end of this report.

Follow up
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 safe findings below.

Community Careline Services

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.

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

Notice of inspection
This inspection was unannounced.

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 Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 used all of this information to plan our inspection.

During the inspection

We spoke with seven people who used the service and four relatives about their experience of the care provided. We spoke with six members of staff including the provider, care coordinator, and nominated individual.The nominated individual is responsible for supervising the management of the service on behalf of the provider

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at one staff's file in relation to recruitment and staff supervision. We looked at a of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found and looked at training data. We spoke with service users, family members and staff following on from the site visit.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- There were insufficient numbers of staff employed at the service to ensure people were safe. People told us that staff were often delayed and some visits had been missed. One person told us, "It's not good. They come when they want. I have had 2 missed visits. Sometimes they come at 10pm at night."
- Staff told us they were exhausted. One staff said, It's very stressful. Staff end up feeling guilty. We work 12 days on 2 days off and then get asked to work our weekend off." Staff did not feel valued and they were concerned for the people they supported. Rotas were not being managed effectively. The care coordinator who was doing the rotas worked part time and was rarely in the office. One person on a 2-1 package of care did not always receive 2 carers and this meant that they could not get out of bed.
- We were made aware that the previous registered manager, office staff and several carers had left the service in April and the service had deteriorated since then.The local authority had stepped in and transferred some people's care to other providers as the service could not meet people's needs safely.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staffing was effectively managed. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We looked at recruitment, although this had been limited. We looked at one individual's staff file and saw that recruitment processes were safe. We saw evidence of interviews and appropriate checks and references that had taken place. The provider told us that they had recently employed a designated staff to help manage recruitment and were organising a recruitment open day.
- The provider responded promptly to our concerns and told us that a new designated coordinator would take responsibility for the rotas.
- People told us they liked the fact that they had regular, consistent staff teams when staffing levels were stable. They recognised that the issues at the service were of a managerial nature and were full of praise for the carers. One person told us, "The night [relative] became ill they were brilliant with her." Another person said, "I'm very, very happy with carers. They make my husband giggle and he doesn't laugh much so that's lovely!"

Using medicines safely

- Medicines were not being managed safely
- People told us that they did not always get their medicines at the right times. One person told us. It's very bad, they aren't coming when they should. I take medication for anxiety and depression and I need to take it at the same time each day. The GP says it's not working because of this. Another person said, "I need to have my morphine tablets every 12 hours, it's not good."

●We looked at medication administration charts (MARS) and saw there were gaps in recording. There was missing information on the MARS and blister packed medication was not being signed for individually. People we spoke with had concerns around one staff member, who was not completing the MARS sheet appropriately.
●Medication competency checks were not taking place and medicine audits had not taken place for several months. The checks that had taken place previously were not robust enough. We discussed this with the provider who gave this responsibility to the new coordinator to oversee. We were made aware that recent medication training that had been organised did not take place due to technical problems. However, following on from inspection we were advised this had taken place.

The provider failed to ensure systems were in place to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management
● People told us that they did not always feel safe and communication was poor at the service. The on-call system was not fit for purpose. People told us, "Community careline has gone to the dogs," and "It's a shambles. They don't let you know. When I tell them it's like talking to a sponge." People told us they couldn't get through to anyone. One person told us, "It's not fair, but I'm very disabled and can't cope on my own. If you ring Care Line office or on call they never answer the phone."
● People had not always been informed when their visits could not be covered. This resulted in much anxiety and lack of dignity, with one person missing their personal care and others having delayed medication and missed mealtimes. The current rota system did not flag up where visits had been missed or where there had been duplication in the rotas.
● One person told us that staff had been expected to use equipment that they had not been properly trained to use. We raised this as an issue to the provider but were made aware that they no longer supported this individual.
● Risk assessments did not always address specific risks and care plans required further work as they were not as personalised as they should be. However, the provider was in the process of implementing a new care planning system. The area manager showed us that these care plans would be much more personalised.
● We did not see evidence of care plan reviews taking place and found discrepancies in commissioned hours relating to one person's care.

The provider failed to ensure systems were in place or robust enough to demonstrate risks were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider was in the process of implementing a new care planning system. The area manager showed us that these care plans would be much more personalised.

Systems and processes to safeguard people from the risk of abuse
● The provider had safeguarding procedures in place to help protect people from harm. Staff had received safeguarding training and were confident in raising concerns. They had alerted the relevant agencies appropriately when staffing levels had fallen to low levels.

Preventing and controlling infection
● Infection control was managed safely. Staff had received training and were aware of their responsibilities regarding infection control. Staff told us they had access to adequate personal protective equipment and

that they received regular Covid 19 testing, in line with current government guidance.

Learning lessons when things go wrong

● The provider had learned lessons when things had gone wrong recently. They acknowledged that the issues found on inspection should have been addressed sooner and an immediate action plan was submitted. Meetings had taken place with the local authority and CQC and the provider and the new manager had provided weekly updates. A new area manager had been recruited since inspection and a full-time care coordinator now had responsibility for rotas. The provider was receptive during the inspection process and was keen to make to changes to improve the service.

● Accidents and incidents were not being recorded appropriately. We raised this as an issue with the area manager who agreed that these would be recorded and analysed.

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.

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

- There was a lack of clarity and management oversight at the service. We had received concerns prior to inspection around missed visits and about the registered manager and several staff leaving in April. We had not been notified of this change and had not received any communication from the service to inform us who was managing the service. We had also not been notified of the severity of the staffing issues the service was experiencing. The area manager apologised and admitted that this had been an oversight on their part. This is being dealt with separately outside of the inspection process.
- Quality assurance systems were not in place. There was no monitoring of the quality of care being received. There was a lack of audits taking place and no spot checks taking place.
- Governance was poor and there was a lack of oversight from the provider. There were no provider audits taking place and the issues that we found on inspection had not been picked up. Communication with people and staff was not good and the culture of service had not always been transparent.

The provider had failed to ensure systems for governance and management oversight were robust and effective. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

- A new manager had been appointed but had not yet applied to become the registered manager. The manager had not been at the service long and was not available at the time of the inspection. However, following on from the inspection the manager provided reassurances and gave us regular updates on the action plan that was submitted.

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

- People's experiences had not always been positive. The service had deteriorated, and people had experienced negative outcomes. The local authority had stepped in and transferred some people's care to other providers in an emergency situation which was unsettling for them.
- Staff told us that the service had gone downhill and they didn't feel valued. Staff had been working extremely long hours and felt stressed.
- However, people we spoke with told us it had not always been that way and had coincided with changes at the service and the departure of the previous manager and several staff. People told us that they enjoyed the consistency and continuity of having regular carers based in geographical areas. Staff we spoke with

knew the people they supported extremely well and service users spoke highly of the caring, compassionate staff.

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

● The service had not carried out service user satisfaction surveys to gain the views of people who were currently being supported. Staff had also not been consulted or asked for formal feedback. Staff we spoke with told us that team meetings were not taking place and that they were concerned about changes to electronic care planning. We discussed this with the provider who reassured us that engagement with staff and service users would be taking place.

● Staff told us that they had started to receive supervisions with the new manager. One staff told us, "I've met with [new manager], she has been great, I've had supervision and met her a few times in the office. I feel well supported."

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 service understood the duty of candour and were aware of their responsibilities. The new manager had already contacted some service users following our feedback and addressed issues with them. Feedback about the new manager was positive and we saw evidence of complaints being dealt with appropriately and apologies given.

Continuous learning and improving care; Working in partnership with others

●The provider responded promptly to the concerns during the inspection and immediate improvements took place.

●The area manager told us that she had resigned and we had concerns about what support mechanisms would be available to the new manager. However, following inspection the provider reassured us and informed us that a new area manager had taken over at the service.

●The provider had already identified that the current rota system was not picking up duplicate and missed calls and was in the process of changing the system.

● Following on from inspection there had been improved communication and liaison with other agencies and the local authority and regular multi agency meetings were taking place.

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 The provider failed to ensure the proper and safe management of medication. The provider failed to ensure that people received safe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems for governance and management oversight were robust and effective.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of staff were deployed to ensure people's safety.