Liberty Carers Limited

Caremark (Redbridge & Waltham Forest)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Caremark (Redbridge & Waltham Forest) is a domiciliary care agency providing personal care to 70 people in their own homes in North East London.

People's experience of using this service and what we found
People were not kept safe from the risk of abuse. The provider's safeguarding system was not effective, and not all staff had been trained about how to safeguard people from abuse. Medicines were not always managed safely.

People and their relatives told us staff did not always wear personal protective equipment such as masks and gloves when staff were supporting them.

The provider's recruitment process was not robust enough to ensure staff were of suitable character to work with adults at risk which put people at risk of harm.

People and relatives told us the provider did not have enough staff to keep people safe and meet their needs. People's care visits were regularly missed or started late.

People and their relatives told us staff did not always have the right knowledge and experience to effectively support people in line with their needs and preferences. Staff had not received training about providing care with dignity in a person-centred way. People told us they were not supported by a consistent staff team but their more-regular carers were polite and friendly.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

The provider did not have a system to monitor the quality of the care provided. The provider did not manage complaints well. People and their relatives told us they did not feel listened to. The service's culture was not open and empowering. People and their relatives were not routinely asked to feedback about their experiences of the care provided. People told us communication with the office was difficult. There was a new management team in post at the service and people told us some improvements had begun to be made but there was a lot more progress that needed to be made.

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 27 January 2020).

Why we inspected
We received concerns about people being at risk of abuse. As a result, we undertook a focused inspection to review the key question well-led and key line of enquiries from other key questions. During the inspection we found other concerns and broadened the inspection to look at all five key questions.
We reviewed the information we held about the service. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Caremark (Redbridge & Waltham Forest) on our website at www.cqc.org.uk.

Enforcement
For enforcement decisions taken during the period that the 'COVID-19 – Enforcement principles and decision-making framework' applies, add the following paragraph: 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding people from abuse, person-centred care, staffing, recruitment, receiving and acting on complaints, dignity and respect, safe care and treatment and good governance at this inspection.

We have made a recommendation about meeting communication needs.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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? The service was not safe. Details are in our effective findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Caremark (Redbridge & Waltham Forest)

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 team consisted of two 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 care service.

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

This inspection was unannounced.
Inspection activity started on 8 September 2021 and ended on 15 October 2021. We visited the office location on 8 September 2021.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two staff members, the new manager, and a care coordinator.

We reviewed a range of records. We looked at 31 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found and issued a letter requesting more information some of which was provided. We looked at training data and care plans. We spoke with 15 people who used the service and five relatives of people who use the service. We tried to contact 31 members of care staff and spoke with four carers.

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.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of abuse. The provider's safeguarding systems were not effective and where allegations of abuse had been made the provider had not followed their policy and withdrawn the staff member from duty to protect them and others.
- The provider did not have accurate records about concerns such as the outcome of investigations and actions taken to keep people safe. The provider had not notified the CQC about allegations of abuse as required to do so by law.
- Not all staff had received safeguarding training, including an alleged perpetrator of abuse, which was contrary to the provider's policy.
- Although staff we spoke with knew they had a duty to report concerns, not all staff felt confident to raise concerns about poor care and abuse. One staff member said, "You can't trust everyone at [service name]."

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

Staffing and recruitment

- The provider had not deployed staff safely to ensure people's needs were met. People and their relatives told us there were not enough staff and their care visits were missed or late. A relative told us, "there have been some missed calls. Sometimes we're told when they're running late but not often." A person told us, "They're not often on time – more often than being on time. Occasionally they haven't come at all." Three times they've forgotten me so my [relative] has to phone up."
- People and their relatives told us staff did not stay for the allocated time, rushing tasks and not taking the time to talk to them. A relative said, "I have seen carers breaking down, the carer turns up late and apologise that they will not be able to give me the allotted time… My carer had just turned up and… got a call to saying to leave to go to another call."
- Staff told us there were not enough staff and there was not always a second carer where one was required meaning people were at risk of unsafe care. A staff member told is "There is not enough staff… Sometimes we can stay the full visit depending on how many visits you have on that day. Some clients don't get all their visits in a day due to no staff available… sometimes you could be left on your own because they have a shortage of staff."

The above issues amount to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The new service manager who had been in post for five weeks at the date of inspection had begun a

recruitment drive to hire more staff. We saw interviews being carried out during the inspection.

● The provider's recruitment system was unsafe putting people at risk of harm. The provider did not always make enough checks to ensure staff were suitable for working in the caring profession, such as criminal record checks and taking employment histories.

The above issues amount to a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured by the provider's measures for preventing and controlling infection. People and relatives told us staff did not always wear personal protective equipment (PPE) when providing personal care. A person said, "Sometimes they wear PPE, sometimes they don't." A relative said, "They always [wear a mask] but now and again I do have to remind them about handwashing."
● We observed stocks of PPE were held at the office however a staff member told us, "Sometimes they do run out of gloves. I've had to wear a size that was smaller than I needed. But I've never had to give care without PPE."
● Information we held about the service and what a relative told us demonstrated people were not always confident about senior management's approach to COVID-19. The relative said, "the company is not COVID friendly. [Senior management] thought Covid was a load of rubbish and that ran through the company. One carer wouldn't wear PPE but the rest did."

The above issues amount to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The provider did not always manage medicines safely. Medicines administration records (MAR) were not accurate and contained gaps meaning we were not assured people were receiving their medicines on time.
● Not all of people's medicines, such as prescribed creams, were on their MAR meaning we could not be assured they were being administered. Side effects of medicines were not captured in their care records or MAR so staff did may not have known how to check people for signs of adverse reactions.
● The previous registered manager had not been auditing MAR to check for errors and had not taken action to ensure people were kept safe from unsafe medicine administration. The new manager told us they had created a new system to check for errors and we saw that one error had been responded to appropriately.

The above issues amount to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● The provider had identified the risks people faced, such as environmental risks and mobility support needs, and had provided staff with brief written guidance about how to mitigate against them. However, for one person records were not clear enough for carers to know what catheter care was required.
● The provider had included recommendations from health care professionals about how to prevent harm from pressure sores.
● The provider had captured which equipment people needed to use to minimise the risk of harm from falling.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider did not always ensure staff had the right training and skills to support people effectively in line with their needs.
- Staff told us they wanted more training to carry out their roles. One staff member said, "Training that I had when I first started was before COVID. Since COVID, nobody has had in-person training. You can't beat in person training. The quality of training I had was okay." A second said, "I'd like more training. It's beneficial as a reminder.
- There was no straight forward system of overseeing who had received training relevant to their roles so the newly appointed manager did not know who had received training. Records showed that not all staff had received the provider's standard training such as safeguarding training.
- People and relatives told us their care was provided to inconsistent standards and newer staff did not know how to support them effectively. A relative said, "Not sure about the training, but some carers do not know how to [complete care task], that is basics I would have thought."
- Staff told us they had not been receiving effective supervisions to discuss their support needs. One staff member said, "[We have not had} one to ones. I've got a team leader who I do get on with but it seems they don't have the power to say yes or no."

The above issues amount to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The new manager told us they would address staff training and support. One staff member said they felt supported by the new care coordinator.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; 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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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

- The service was not always working within the principles of the MCA. The provider asked relatives to sign plans of care on behalf of people who could not sign their names. However, the provider had not ascertained whether they had the legal authority to make that decision on their behalf.
- Care tasks referred to providing care in line with a family member's preferences but there was no proof that these decisions were made in line with best interests principles with the appropriate legal authority.

We recommend the provider seek support and guidance from reputable sources regarding working within the principles of the MCA

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- The provider supported people to access healthcare if required. Most people reviewed received this support from family members however, care records captured where the provider was required to provide support instead.
- Care records contained people's medical background and health professional contact details.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- Although people and their relatives told us most care staff were friendly and nice, they did not feel well supported because their care teams were inconsistent. A person said, "The carers are very nice, this is a very big help for me, I often get a lot of different carers at the weekend." A second said, "(Name of Carer) gets on very well with my Family Member and is very caring, although they do arrive late some of the time."
- The provider did not respect people's dignity and diversity because people and relatives told us they were not always supported by a male or female care worker in line with their support needs. A person said, "They're supposed to help me wash and to exercise… but I'm only confident with the men... I've heard they're trying to send me men now." Human rights are underpinned by principles such as dignity therefore this practice may not support human rights principles.
- The provider had received safeguarding concerns and complaints alleging staff did not always treat people with dignity and respect in accordance with their protected characteristics. The provider did not have a plan to improve the service in this area, such as providing further support for staff to promote people's dignity and person-centred care. Daily notes of care did not contain enough detail to assess whether people received care in line with human rights principles.

The above issues amount to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us their independence was supported. A person said, "They encourage me do as much as I can They help me get dressed and They are all very nice to me, I am getting to know them all." Care records gave examples of what people could do for themselves and where they needed more support.
- Care records had space to capture any preferences about people's culture and religion. For example, one person's records contained greetings in their first language for carers to read and use when talking to the person.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The provider did not use complaints and concerns to improve the quality of care. People and their relatives told us they were not confident the provider would listen to their concerns. A person said, "No point in complaining as it falls on deaf ears." A second said, "I'm tired of emails saying 'we're going to look into this and we'll get back to you'. They never do. No-one's been to assess recently, despite their promises. There's been no contact at all."
- There was no log of complaints, including trends and action plans, made since the last inspection meaning they could not be used to improve care.
- The new manager was open to feedback but the provider's systems needed to be improvement to ensure care improved. A person told us, "There seems to be a block at the top – they don't listen. I've told them to look after their staff and they agree but seem a bit powerless. They do seem to be listening a bit more recently but could be more cohesive." Records showed the new manager recorded they had dealt with one complaint since they had been in post. The initial response to the complaint was detailed however there was no investigation or action plan about how the service would be improved.

The above issues amount to a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they would let people know to complain to the management if they had any concerns.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- The provider did not always plan personalised care. Care records did not always contain enough detail about people's personal care preferences. For example, one care record briefly stated, 'I would like my carer to encourage and support me with my personal care.' A second required staff to advice or prompt personal care with no further information about how to do it.
- Care plans were inconsistent and unclear. For example, care records contained reference to he and she meaning it was unclear if the text applied to the person or had been copied from other records.
- Care records were not always updated if someone's needs changed. One person's records stated, 'Apply creams if prescribed' rather than accurately reflecting their current care needs putting people at risk of not getting the correct support.
- Care records had space to capture people's advance decisions but records we reviewed were blank and there was no evidence that people's choices about the end of their life had been explored where appropriate.

The above issues amount to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care records contained brief background information about people so care staff could know more about the person they were supporting.

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's communication needs were not always fully explored and accommodated. Four out five of the care records we reviewed contained communication plans however, one person who had a visual impairment did not have a communication plan. This meant they were at risk of not being supported to communicate their care needs.

We recommend the provider seek support and guidance from reputable sources to develop a system to meet people's communication needs.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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;

- There was not a positive and open culture at the service. People, their relatives and staff told us they did not feel involved and consulted by the provider. A person said, "I'm not really asked for my views but I'd give them if necessary." A relative said, "The company seems to have lost sight of the fact that they are accountable." A staff member said, "Generally you don't get support. You try and air concerns but they don't listen."
- The directors and management team were not approachable. A person said, "I think new Management have come in, there has been so many people leaving." A relative said, "I never see the management." Staff told us there were no staff meetings they could attend to support them carry out their role. Records showed the last staff meeting was held in August 2020.
- Staff morale was low. A relative said, "The company don't seem to support the staff. They're often not happy when they arrive. They're not appreciated by the company." A staff member told us there was a "toxic environment" at the service.
- The previous registered manager had not notified the CQC about incidents that they were required to do so by law. The new service manager was not conversant in their reporting responsibilities.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The management team had not embedded a learning culture at the service and the provider did not have systems to monitor care quality and risks.
- People and staff told us the service was not well run. A person said, "The left hand doesn't know what the right hand is doing." A staff member told us, "There's a lack of communication…The manager recently left but things are still carrying on…People have been there a long time and maybe they're controlling the strings."
- A local placing authority had carried out a recent monitoring visit and had given the service a red rating. The two Directors had told the local authority they would be frequently be based at the service to ensure they had oversight of the risks and care quality. At our inspection the Directors were not present and there were no records to demonstrate their weekly input into care quality and delivery.
- The provider had not conducted any internal audits or inspections of the service to improve safety of care delivery. The provider's policy stated staff would receive regular spot checks to check their performance.

Records showed that since the last inspection only two spot checks had been completed for the same member of staff. A relative told us, "[There are no spot checks] that I know of."

● The new manager had been in post for five weeks. They told us they were aware that substantial improvements needed to be made and they had not had time to set up monitoring systems yet. People and their relatives told us that some improvements had started but these needed to be properly embedded at the service. A person said, "Things had started to improve, but still a lot of room for improvement."

Working in partnership with others

● The provider did not always have effective partnerships with health and social care professionals and people who used the service.

● The local placing authority had required the provider to send surveys to people and their relatives to get their views about the service. The surveys had been drafted but not been sent to people by the time of our inspection.

● At the request of the local authority the provider had created an improvement plan however this had not included all the concerns highlighted in this inspection such as missed and late care calls, ineffective training, concerns about infection control and acting on complaints.

● The provider had not reported incidents to the local authority and CQC as required by law.

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

● The new service manager had recently applied to the CQC to be the registered manager of the service.

● The new service manager told us they planned to develop systems to monitor and improve service quality. For example, following a medicines dispensing error by a pharmacy the manager had worked with the pharmacist to correct the error and keep the person safe.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not always meet their needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with respect with due regard to relevant protected characteristics.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not effective to protect service users from abuse and improper treatment.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not established an effective system to handle complaints.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not effective to

ensure fit and proper staff were employed.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, skilled and experienced staff deployed.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not established safe infection prevention and control measures. The provider had not safely managed medicines.

The enforcement action we took:

We served a warning notice on the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effective to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

.Served a warning notice on provider.