

Carby Community Care Ltd

Carby Community Care

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

This service is a domiciliary care agency. It provides personal care to people living in their own homes. At the time of the inspection, 31 people were using the service.

People's experience of using this service

People's experience of using the service varied. Those who were regularly attended by experienced or enthusiastic newer care workers spoke highly of them and we received exceptional or very good feedback about named members of staff. Others commented on the high turnover of staff and lack of skill in staff. Comments we received included, "They are absolutely wonderful, so helpful" and "Some staff do the minimum and get away with it."

Staff training arrangements had been impacted by the Covid-19 restrictions, and since then not all inductions and refresher training had been completed. The service had begun to use online and video training but there were still significant deficits which potentially put people at risk. For example, people were being supported with their medicines by staff who had not been recently trained in the management of medicines or had their competency suitably assessed.

Medicines records were not always being correctly kept. People's medicines assessments did not always contain all the information required to keep them safe. Audits of these records failed to identify many of the issues we found. Appropriate action had been taken where issues had been identified.

People told us their care workers usually arrived as expected but this was not always consistent. It was a common belief among people and their relatives that the service was short staffed.

The service was not keeping effective records of quality issues, complaints, safeguarding alerts and incidents. The manager described areas of improvement being looked into at the time of inspection, but these were not formally documented in an ongoing improvement plan.

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

Rating at last inspection (and update)

The last rating for this service was requires improvement (published 15 July 2019) and we found a breach of the regulations relating to management of medicines.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. 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 Carby Community Care Ltd on our website at www.cqc.org.uk.

Enforcement

We have identified a breach in relation to the safe management of medicines and the governance of the service at this inspection.

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

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.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Carby Community Care

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 an Expert 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.

Service and service type

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

The service did not have a manager registered with the Care Quality Commission. A registered manager is a person who is legally responsible for how the service is run and for the quality and safety of the care provided. It is a requirement of the provider's registration that they have a registered manager.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or interim manager would be in the office to support the inspection.

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 professionals who work with the service. 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 reviewed a range of records, including six people's care plans, care notes and medicines records. We looked at recruitment records for three members of staff. We reviewed documents related to the running of the service such as policies and procedures. We spoke with three people who used the service and ten family members. We spoke with five members of staff.

After the inspection

We continued to seek clarification from the registered manager to validate evidence found.



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.

Using medicines safely

At our last inspection the provider had failed to ensure the safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some improvements had been made, the provider was still in breach of regulation 12.

- Care staff had not all been trained in the safe administration of medicines, and their competency had not been assessed. Staff had started unsupervised work, including the administration of medicines, before completing medicines training. Longer serving staff had not had annual refresher training. This put people at risk of being supported by staff who did not have the required skills and knowledge to manage their medicines safely.
- Medicines administration records (MAR charts) were not always being completed correctly by staff. For example, one chart did not have dosage and frequency correctly recorded and was inappropriately using the "not required" code when the medicine had not been prescribed for that visit. Charts had unexplained and unsigned corrections, including the changing of initials on a day's records and corrections of the dosage required.
- Risk assessments and medicines administration records (MAR charts) did not always contain enough information to ensure people's safety. For example, one person was to be supported to take a controlled drug for pain relief when they required it, but the required dosage was not noted on the MAR chart or on their list of prescribed medicines. This put them at risk of being given the wrong dose of a controlled drug. Further, it was noted in their assessment that this person had an inhaler which they self-administered but not what it was or what it was for, and there were non-prescribed medicines listed on the MAR chart which were not in the assessment. This lack of clarity could increase the likelihood of errors.
- Although the service had improved the form used for auditing MAR charts, audits we saw had failed to identify the errors and issues described above. Other minor issues, such as care workers occasionally forgetting to complete the chart, had been identified and appropriately followed up.

This was a continued breach of 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since the last inspection, the service had stopped issuing fines to staff who made errors in medicines administration or recording. This reduced the risk of staff failing to report errors. Staff told us they would report any mistakes they made.

- People were encouraged to be as independent as possible with their medicines. Appropriate assessments and record keeping were in place when people sometimes took their own medicines and were sometimes helped by staff.

Staffing and recruitment

- Safer employment checks had not always been fully completed before care staff began work. We saw that recently recruited staff had verified references but some did not have a complete employment history, including explanations of any gaps. The acting manager took action to address these gaps by the end of the inspection and told us that all staff records would be checked.
- Disclosure and Barring Service (DBS) checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.
- Although many people spoke highly of their regular care workers, there was a high turnover of staff and this impacted on people's experiences. People told us, "They told us they were short staffed" and "Reliability is poor and they are short staffed." The acting manager told us that recruitment had been difficult during lockdown.
- People and their relatives told us their care workers mostly arrived at around the expected time and completed their tasks, but this was not always consistent. Comments we received included, "[Relative] doesn't like the weekend staff as they are late and do as little as possible" and "Those that came in the evening were no good, they didn't do anything and I had to do it again after they had gone." Electronic call monitoring (ECM) records confirmed this lack of consistency.
- Staff told us their rotas were usually practical and that they had enough travel time. However, several staff mentioned that their rotas were confirmed on a day to day basis. This lack of certainty would affect the consistency of the service.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The acting manager told us there had been no safety incidents or accidents since the last inspection. Safeguarding records were kept in the person's file and included records of the investigation and outcome. There was one substantiated allegation of abuse in the past year and appropriate action had been taken.
- Staff had a basic knowledge of safeguarding and understood their responsibilities to report any concerns. They confirmed they had received training in safeguarding adults during their induction although this training had not been refreshed. They were confident that any concerns they raised would be escalated appropriately, but knew they could speak directly to social services or the CQC if they were not satisfied. Staff said, "I would ring straightaway if I thought someone wasn't getting proper care" and "Anything I don't think is right, I would call the office."

Assessing risk, safety monitoring and management

- People told us they did not always feel safe, particularly in relation to moving and handling. Relatives told us, "Staff did not know how to move and handle" and "We only trust [staff name], and if anyone else tried to help ... I would stop them as I don't think they are experienced enough." Others said this was an area the service had improved in. A relative told us, "It's OK now as the carer comes on time and stays to make sure [person] is safe before she leaves." The acting manager told us that staff moving and handling training had not been refreshed due to Covid-19 and that they were in the process of sourcing alternative training providers.
- Risks to people were identified at the initial assessment and measures put in place to minimise these risks. Risk assessments we looked at had been completed in a suitable level of detail and were recently reviewed. The format of the risk assessment asked clear and useful questions but space was limited to answer them.

Preventing and controlling infection

- The service had infection control policies and procedures in place, and staff told us they had a plentiful supply of personal protective equipment (PPE). There were procedures in place should a person using the service or a staff member have Covid-19.

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 requires improvement. At this inspection this key question has remained the same. 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; Continuous learning and improving care

- There was no registered manager in post. The last registered manager left in April 2019. Since that date the service had employed two potential registered managers who left before their application to register was submitted. The service was currently seeking a new manager and there was an acting agency manager in charge along with a care co-ordinator and an administrator.
- The lack of experience in the management and care team had sometimes had a negative impact on the service. We identified issues with quality management, recruitment, medicines management and training as described elsewhere in the report.
- Following the last inspection, the service had drawn up an action plan. There was no updated version of this available. We were given an action plan which was a general overview of the agency's current position and planned action. There were no clearly defined objectives with timescales for improvement.
- The service was not effectively managing complaints and concerns. Several people or relatives that we spoke with confirmed they had complained to the office but many had not been satisfied with the outcome. Comments included, "It's a constant battle to get things sorted" and "There wasn't any change when we complained and they tried to make us feel bad for complaining." Another person told us, "I put things in writing to Carby if we need to. We complained about them not turning up and they did respond." There was no central record of complaints and concerns, which would make it difficult to have oversight of where improvement was required.

Failure to assess, monitor and improve the quality and safety of the services provided is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Many people or their relatives told us that the office did not communicate well with them. They told us that they were not advised of changes to their service, such as when their care worker was running late or had left and was being replaced. People told us, "They don't communicate. I only have problems when my normal good carer is off. They don't tell me who is coming and they are late, mostly." However, one member of the office staff was praised by many people. One told us, "On the phone there has been no issues, very efficient. [Staff member] phones to make sure mum is OK, it's a very good care company."

- Each person's records included the contact details of professionals involved in their care. Care workers confirmed they worked with professionals when required, such as district nurses and palliative care nurses.
- Staff told us they were usually well-supported by the office staff and any queries, such as those related to pay, were dealt with satisfactorily.

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

- People's experience and outcomes varied. Positive remarks included, "Staff know what they are doing or [person] explains it to them. They are quite gentle. Everyone's been perfect" and "They are exceptionally kind and caring." However, other people raised concerns as described elsewhere in this report. Relatives told us, "[Care worker] takes things personally and loses their temper" and "They leave silly things undone and I have to check."
- Some of the people and relatives we spoke with described good, person-centred care. They told us care staff encouraged independence and promoted their wellbeing. Relatives told us, "[Person] showers themselves with support from the carers" and "Most staff prompt day to do things rather than doing them." Several people and relatives named staff members who they considered to be excellent. They told us, "[Name] is marvellous... they set a good example to the others and we all like them" and "The running [of the service] is not good at all but [staff name] is great and makes sure we are OK."
- Some of the staff we spoke with were very enthusiastic about their role. Comments included, "I enjoy my work and I love the people I work with, I'm a caring person, I love to care for people and all my clients are lovely", "I like looking after people" and "I like my clients very much."

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 acting manager had sent in statutory notifications relating to allegations of abuse or neglect.
- The service's rating was clearly displayed and was on the front page of their website.
- The acting manager was responsive to the issues raised during the inspection and where practicable, took immediate action to rectify errors.

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 did not ensure the proper and safe administration of medicines. Regulation 12(1) and (2)(g)
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the services provided. Regulation 17(2)(a)