L & M Care Limited

Caremark (Welwyn & Hatfield)

Inspection report

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15 July 2016
18 July 2016
19 August 2016

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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

We carried out an unannounced focused inspection on 15, 18 and 19 July 2016 in response to an on-going safeguarding investigation into the death of a person using the service. At the time of the inspection, the service provided care and support for 78 people living in their own homes.

The service did not have a registered manager and there was no manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we identified significant concerns in relation to the safety of people using the service and the overall management and leadership in place. As a result we served a notice to restrict any further admissions to the service on 22 July 2016. The provider had informed us on 19 July 2016 that they were insolvent and due to appoint liquidators the following week, which meant that people had to be found alternative care providers by the local authority. The provider subsequently applied to cancel their registration of the service on 22 July 2016 which meant that no further care or support would be provided from this location.

People were exposed to a risk of avoidable harm as a result of inadequate management and a consistent failure to monitor their care and support needs. People did not receive their visits on time and these were frequently reported as having been missed or late. Despite the demonstrable impact upon people, the service had not developed effective systems to monitor this or identify ways in which it could be improved.

People's medicines were not managed safely and they did not always receive them on time. Staff were trained to administer medicines, but people's care plans did not contain sufficient information to support them to understand people's needs. The medicine administration records kept to account for people's medicines contained gaps, errors and were not audited efficiently to identify ways to improve upon this.

The service did not have a registered manager and there was no consistent, stable management or leadership in place. People and staff did not feel that they were listened to and did not have confidence in the management of the service to improve. The quality monitoring systems in place were inadequate for identifying improvements that needed to be made, and the lack of managerial oversight in the service meant that changes were not made as required. The service did not follow their own policies in relation to people's care and support, and people were receiving inadequate care as a result.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Medicines were not managed, audited or administered safely.

People did not receive their visits and support on time.

The service did not follow safe recruitment procedures to ensure that staff had were safe to support people using the service.

Is the service well-led?

Inadequate

The service was not well-led.

There was no consistent leadership or management in place.

Staff did not feel supported by management.

The systems for monitoring quality were ineffective.

Caremark (Welwyn & Hatfield)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15, 18 and 19 July 2016 and was unannounced. The inspection was carried out by two inspectors and an enforcement inspector. An inspector made calls to people, their relatives and staff on the second day.

Before the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We also reviewed the reports from local authority monitoring visits.

During the inspection we spoke with nine people who used the service, seven members of staff and the regional support manager. We looked at the care plans for 20 people, which included risk assessments, guidelines, healthcare information and records relating to medicines. We looked at eight staff files including recruitment information and training records. We also looked at quality audits, satisfaction surveys, minutes of meetings and complaints received by the service. We reviewed information on how the quality of the service was monitored and managed.

Inadequate

Is the service safe?

Our findings

At our last inspection in February 2016 we identified concerns that people were not receiving their visits on time, staffing levels were unsafe, and that some visits were being missed. We also found that people's medicines were not being properly managed and that people did not receive their medicines on time.

During this inspection we found that the management of people's medicines had not improved. We looked at the MAR (medicines administration record) charts for 23 people and found that 57 of 60 charts we saw were completed incorrectly. There were significant numbers of gaps on some MAR charts which were not adequately accounted for, and occasions where MAR charts had been signed using a numerical code. On several occasions the code was used for 'not given for any other reason', but no reason had been specified. When we asked the deputy manager about this, she explained that sometimes people's families administered their medicines and that this accounted for the gaps. However there was no record of how this had been evidenced in care plans or validated by the staff responsible for cross-checking the charts. Monthly audits were carried out to identify these gaps, but the action taken was not sufficient to prevent recurrence. For example we saw on one audit that it was written 'no action' was taken because the care staff in question had left. However when we checked the daily rotas , we found that some of the staff mentioned as having left the service were still working for the service. This meant that the gaps and mistakes were not always being addressed. While we saw evidence that staff were reminded of their duties in this respect through team meetings and supervisions, there had been no improvement in the accuracy of these records over time. Failing to account correctly for people's medicines meant that they might have not received them as prescribed or at the time they were supposed to be given.

The consistent failure to manage people's medicines effectively had resulted in at least one example of avoidable harm to a person using the service. We saw that on 31 May 2016, a healthcare professional had emailed the manager to alert them that the level of support the person required with their medicines had changed and that an urgent review was required. However, there had been a three week delay in responding to the professional despite the seriousness of the concerns raised. By the time this had been dealt with, the person had missed two doses of their medicines, which resulted in them having an epileptic seizure. It was of concern that this had not been dealt with in a timely manner and had consequently, put the person at risk of significant harm.. Additionally, when we reviewed this person's care plan, we found that there were three separate and undated care plans that contained contradictory information about the support the person needed with medicines. The person's risk assessment stated that there was a 'low risk' to the person if they missed their medicines, despite them being at risk of having epileptic seizures. The person's MAR chart for June 2016 had only been signed on seven occasions. The field care supervisor had left a note on the chart saying they had 'spoken to staff', but there was no evidence of action being taken to improve the standards of record keeping.

People's care plans did not contain sufficient information for staff to understand how and when people took their medicines. PRN medicines are medicines given on an 'as and when' basis and require protocols in place to ensure that staff know when it's appropriate to administer them. Some people who needed creams applied did not have accompanying MAR sheets in place. Staff were asked to sign to indicate that they had

administered a whole blister pack instead of signing for individual medicines. This meant that staff were not always aware of what they were administering to people and could not account for individual medicines safely.

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

People and their relatives told us that they continued to experience late and missed visits. One person said, "The weekends seem to slip and a lot of regular carers take time off. They don't realise that just because I'm disabled I have a life of my own to live. They don't always let me know they're late." This person also told us that staff had arrived for a 10pm visit at 6pm the previous evening and attempted to put them to bed. Another person described the impact of missed visits on their health. They said, "It's much worse at weekends. I need to move every three hours or I get sore. One night recently somebody was due to come out and put me to bed at 10pm and they didn't come out until 12pm, so I was sitting down for far too long. And then they said that it was me who cancelled the call. It's highly irritating." A relative told us that they had been forced to provide care themselves, and told us, "It was always quite late before recently, I've had to get family in a couple of times because of late calls. I've had to cancel them at times because they've been so late. Sometimes they know I'll get family in so they've cancelled the calls on purpose, which really wasn't good enough."

The service had recently reduced significantly in size due to continued difficulties meeting people's needs and providing care on time. On the weekend of 25 to 28 March 2016, there was a large number of staff who were absent at once, meaning that a significant amount of visits were missed. When we asked for an account of the exact number, this could not be provided to us by the service. However the local authority told us that there had been 24 separate complaints made to them in relation to that weekend. The service had received 18 complaints in relation to missed or late visits since our last inspection in February 2016.

Before the inspection we noted that staff turnover was assessed as being very high for a service of this size. People, their relatives and staff did not feel that there were sufficient numbers of trained and competent staff available to support people safely. One person said, "They seem to have stopped recruiting good staff. I was going to look for another company, but I'm hoping it'll change. They need one or two more experienced staff." Another person told us that staff shortages meant that the staff who supported them were not always skilled enough to meet their needs safely. They told us, "I need to be hoisted and rolled and positioned in a way that makes me comfortable, a lot of the time I have to explain what I need. It's not always safe. The last three months have been really bad."

We were concerned that staff shortages had resulted in occasions where people were being supported by one member of staff when they should have had two. One relative said, "We didn't have any continuity of carers and we didn't want to see different people each time, we wanted regular carers. There were 22 occasions when I had to be the second person because they only sent one. The manager told me it would not happen again, but it happened again the very next day." Another relative told us, "We've had a bit of a problem with one carer coming instead of two. It happened lots of times with a different carer coming in every night." When we spoke to staff they confirmed that they had been asked to provide care alone for visits where people required two staff to support them. One member of staff said, "I've been asked to do a double up call alone 3 or 4 times. I've told them I won't do them by myself and so the call was missed." Another member of staff told us, "I have been asked to do double up calls by myself. It doesn't happen often now, but I can't say I've never been put in that position." When we asked the service for a record of the times this had happened, they were unable to provide us with this information. This meant that the service could not provide evidence of how this risk was being managed or the action taken to prevent this situation from

recurring. Failing to provide adequate staffing for people who required the support of two staff meant that people were put at unacceptable risk of receiving unsafe care.

This was a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always recruited safely to the service. The provider's recruitment policy stated that people would not start work until they had received two satisfactory references and a completed DBS (Disclosure and Barring Service) check. DBS helps recruiters to make safer employment decisions by checking if prospective employees had prior convictions. While the staff files we looked at contained completed DBS checks, some staff had commenced working in people's homes before this had been received. The employment references on file were not always adequate to ensure that staff were suitable and experienced to work in the service. We looked at eight staff files and found that six of these contained references which were not valid. Two staff had been employed prior to satisfactory references being received. One member of staff had been employed and was supervised while working in people's homes before references or a completed DBS check had been received. Failing to ensure that appropriate recruitment processes were followed left people at risk of receiving care from unsuitable workers.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a policy in place for recording and reporting accidents and incidents, however this was not being followed safely and the service was not taking action to minimise the risk of recurrence. While we saw some records of incidents being reported, there was no evidence of action being taken in response to these. For example we saw that one person had suffered a fall and that the staff on duty had recorded this. However there were no actions listed and no updates to the person's care plan to reflect the incident. Incidents were not always reported in line with the provider's policies. For example we saw that one person had suffered an injury when leaving a staff member's car. This injury was later reported by a community healthcare professional but there was no log of this incident and it had not been investigated. Because no action had been taken following this incident, the person had been left at risk of further infection or injury. The failure to keep a record of all incidents and take appropriate action in response to these meant that people were being put at continued risk of avoidable harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2016 we found that people and staff did not always have confidence in the management of the service and that the systems in place to assess and monitor the quality of the service were not effective.

During this inspection we identified further serious concerns regarding the overall governance, leadership and management of the service. Since our last inspection both the care manager and the deputy manager had left and the service was now being managed by a regional support manager. However of the people and staff we spoke with, only one member of the office staff knew who was managing the service.

People told us that they did not feel listened to by management and that there was no response or action taken in relation to their concerns. One person said, "Caremark lacks good management, that's really the problem. They wonder why carers don't stay and want to go somewhere else when it's so badly run." Another person told us, "That's a problem, management. I called up and asked why they'd said I'd cancelled a call when it was them who were late. But you don't get through to anybody." A relative said, "They make a lot of promises they can't keep. When you call up and ask for something, they tell you they'll help out but they never do."

Staff we spoke with told us that frequent changes to the management of the service meant that they did not have stable leadership and support. One member of staff said, "I'm not sure who's in charge. The turnover in the office is really high, there's new people in there all the time." Another member of staff told us, "I don't really know who the manager is. The old manager wasn't very approachable and used to just brush things under the carpet." Staff told us they were not able to contribute to the development of the service because they felt that there was no communication from the office. A member of staff said, "I don't feel like I can ring up the office and tell them that I have a problem. They never call me back."

The service held team meetings each month but these were only for the office staff and did not include members of the care staff. A member of staff told us, "I haven't been to any team meetings, I haven't had a supervision. I haven't had any spot checks or observations. Nothing. No support." Another member of staff said, "I haven't been involved in any team meetings or seen any minutes. They don't invite us." We looked at the minutes from these meetings and found that while they covered a good range of topics, the key messages were not being communicated to staff. For example we saw that the staff who had attended the meeting had agreed that weekly medicines would be written first on MAR charts. However we noted in all of the MAR charts we saw that this had not been changed.

The lack of leadership and management in the service meant that the systems used to plan people's care were ineffective and chaotic. When we spoke to staff about their rotas and the way in which their visits were planned, the majority told us that they did not receive their duty rota until the day before they visited people. One member of staff said, "The rotas are absolutely ridiculous. We're told that calls are time critical, but they don't plan them correctly on the rota so we end up missing people's calls. There's no travel times incorporated." Another member of staff told us, "The calls are late because there's no travelling time on

rotas. I'm getting the rota the night before sometimes so I can't plan my life properly." Because rotas were not planned adequately in advance, staff could not make provisions to ensure that they could meet their schedules. This resulted in high staff turnover and sickness, and also meant that errors or inconsistencies on the rota could not be highlighted ahead of time. A member of staff told us how this had impacted upon people by saying, "They send you a rota and they don't let you know how you're getting from one person to the next. Double ups are usually problematic because there's no planning. They don't let you know how you'll be picked up or what time you'll finish." The consistent failure to manage rotas properly meant that people routinely experienced missed and late visits. The lack of analysis or action taken in response to this since our last inspection meant that we had no confidence in the management to make sustainable improvements, and this left people at continued risk of receiving poor quality care.

The policies operated by the service were inconsistent with the care being provided. We were given copies of a safeguarding policy that had not been updated since 2012, and policies for care planning and risk assessing did not contain any review date to show that they were being updated regularly. The policies for care planning and assessment were not being followed because staff were at times, supporting people before an assessment of their needs had been carried out.

The service's quality monitoring systems for identifying any improvements needed so that people received the care they required had not always been used effectively. We saw evidence that people were asked over the phone for feedback, but this information had not always been used to improve the outcomes for people using the service. Surveys had been sent out to people in November 2015 with very mixed feedback being received in key areas such as visit times, consistency of staff and support from management. During our last inspection in February 2016, we were told that a report and analysis of these surveys would be completed in March 2016. However at this inspection, we found this had not been completed and people's concerns had not been addressed or responded to.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection, we noted that the Care Quality Commission had only been notified of one safeguarding referral and that no death notifications had been submitted. During the inspection we identified four safeguarding concerns and one death that were notifiable. Failing to notify the Care Quality Commission of these events meant that people might have been put at further risk of harm as we did not have adequate oversight of the service to form a regulatory response to incidents.

This was a breach of Regulations 15 and 18 of the Care Quality Commission (Registration) Regulations 2009.