Community Care Worker Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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
Community Care Worker Limited is a domiciliary care service that was providing personal care to 56 people living in their own homes at the time of the inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. People had a range of support needs such as people living with dementia or those who needed support with their mental health, older and younger adults, people with a learning disability and a physical and/or sensory impairment.

People's experience of using this service
People had experienced less-than-good care over a period of five consecutive inspections. Systems were not embedded or were not always effective at identifying omissions and monitoring trends. Staff training was not monitored effectively. Some improvements had been made and further were planned however, this had not yet resulted in people consistently receiving good care.

Staff recruitment had improved so they were recruited safely, however we found not all double up calls were attended by two staff at the same time according to rotas. People were not always protected from infection control risks. Risks assessments were inconsistent; some were in place and detailed, whereas other were not. The management of medicines were not always safe as some creams were being applied that were not prescribed and some guidance was missing for staff.

There was mixed feedback about staff training and some staff felt it could be improved. People were supported to access other health professionals, but improvements were needed to the information available to staff about people's specific health conditions.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Following our feedback, improvements were made to the service checking on people's legal right to make decisions on other people's behalf. People were supported with their diet and nutrition.

There had been some instances of staff discussing inappropriate topics when in people's homes. People were not always involved in decisions about their care. However, people overall felt treated with dignity and respect. People told us they were supported to remain independent and had their privacy maintained.

There was mixed feedback about people's preferences being understood by staff as the staff team could change so people did not always have regular staff. There was mixed feedback about the response to feedback. No one was receiving support for end of life care, however how people would be supported had been considered by the registered manager.

The service worked in partnership with other organisations. People and staff were engaged in the service.

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 11 December 2018). The service remains rated requires improvement. This service has been rated requires improvement for the last five consecutive inspections. At this inspection not enough improvement had been made or sustained and the provider was still in breach of a regulation.

Why we inspected
The inspection was prompted due to concerns received about poor quality care. We have found evidence that the provider needs to make improvements. Please see the full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified a breach in relation to the provider failing to make sufficient improvements to achieve an overall good rating and systems not always being effective at identifying areas for improvement. 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
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. This is because the provider has failed to achieve an overall good rating in five consecutive inspections. 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, 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Community Care Worker Limited

Detailed findings

Background to this inspection

The 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 checked 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.

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.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was also the provider; they are referred to as the registered manager throughout the report.

Notice of inspection
The inspection was unannounced. Inspection activity started on 14 May 2019 and ended on 17 May 2019. We visited the office location on 14 May 2019. We made phone calls phone calls to people, relatives and staff between 14 and 17 May 2019. We also carried out a home visit on 16 May 2019.

What we did before the inspection
We used the information we held about the service, including notifications, to plan our inspection. A notification is information about events that by law the registered persons should tell us about. We also

considered the information of concern we were made aware of when planning our inspection.

During the inspection
We spoke with three people who used the service, four relatives, eight care staff, the operations manager and the registered manager (who is also the provider). We viewed six care files for people, some of which included daily notes and medicines records. We looked at documents relating the management and administration of the service such as audits, meeting records and surveys. We also viewed three recruitment files.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same, requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

• There were not always sufficient staff to be able to support people at the right time. A relative told us double-up call carers may arrive at different times. Rotas also showed there were some occasions when two staff were supposed to attend a call at the same time, but this was not always happening. People may need two staff to keep them safe, such as to help them with their mobility. If only one staff is present, this may put the person at risk.

• Despite this, people and relatives generally felt that staff were able to get to them on time and staff felt their rotas were achievable. One person said, "They're never really late to be fair, their time keeping is generally very good." A relative said, "[Staff] generally turn up on time." A new staff member said, "They've tried to keep travelling down, grouping calls in the same area."

• This meant improvements were needed to ensure two staff were able to get to the planned calls at the same time.

• At the last inspection there were concerns about how robust recruitment systems were and staff suitability to work had not always been checked. At this inspection, we found improvements had been made.

• Staff had their suitability to support people who used the service checked. They had their previous employment references, identity and criminal record checks carried out.

Systems and processes to safeguard people from the risk of abuse

• People may not always be protected from potential abuse. Staff recognised different types of abuse and understood their safeguarding responsibilities. They told us they would report their concerns to the registered manager. However, not all staff knew where they could report their concerns if the registered manager was unavailable. It is important for all staff to know this, so they can report concerns directly to the local safeguarding authority in case the registered manager was absent or if staff felt action had not been taken.

• Despite this, people were being protected as when concerns had been identified these were reported to the local safeguarding authority, as required.

Using medicines safely

• The management of people's medicines required strengthening. We found that some creams were being applied but they were not prescribed. Staff were also not recording the application of these on Medication Administration Records (MARs). For example, we saw in a person's home that there were creams the person confirmed were being applied by staff and we saw documented in another person's records that staff were applying creams that were not listed on the MARs. Only prescribed medicines should be administered by

staff. If a medicine is administered, it should be recorded on a MAR as evidence.
• As some medicines were not being recorded on a MAR, there was also a lack of guidance available for staff, such as where to apply a cream. Body maps, or a Topical Medication Administration Record (TMAR) to indicate where cream should be applied was also not in use, so we could not be sure people were having their creams as required.
• Medicines that are needed 'as and when required', also known as PRN medicine, did not always have additional guidance for staff to help them identify when it may or may not be required. This left people at risk of not always having their PRN medicine when they needed it.
• Despite this, people and relatives told us people were supported to have their medicines.
• The registered manager explained a new electronic medicines system was being introduced which would help ensure staff had the correct information. We will check this system at our next inspection.

Preventing and controlling infection; Learning lessons when things go wrong
• People were not always protected from the risk of cross infection. Relatives told us staff wore gloves, but they did not always wear aprons.
• One relative said, "They [staff] wear gloves. If I'm honest, they don't always wear aprons." Another relative said, "They [staff] don't wear aprons, so there is an issue of cross contamination."
• Lessons had not always been learned when things had gone wrong. For example, some checks had identified that staff were not always wearing their aprons. However, we received feedback that this was still an ongoing issue so action taken had not been sufficient.
• Following the inspection, the registered manager explained they would take action to re-train staff and take further action with staff who continued to not wear appropriate personal protective equipment (PPE).

Assessing risk, safety monitoring and management
• At the last inspection we identified improvements were needed to the guidance available for staff, as it was not always consistent. At this inspection, we found some improvements were still needed.
• For example, some people had started to be supported by the service, however no initial risk assessment about people's needs or their home had been carried out. This meant the service had not fully assessed people's support needs and risks. This left people at risk of receiving inconsistent support.
• There were other examples of risks assessments about people's mobility and the equipment they used to move around their home. Therefore, some assessments were in place, but others were not. This meant it was not always consistent.
• Despite this inconsistency, people told us they felt safe. One person said, "Staff know how to use the ceiling track hoist." A relative said, "Yes my relative is safe, it's how they [staff] watch my relative when they are in and out of their chair."

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 skills, knowledge and experience.
• Staff did not always have sufficient training to support people effectively. There was mixed feedback about staff knowledge and ability. One relative said, "They have a hoist in place, but some staff are not good at using it." Whereas another person told us staff did know how to use the hoist. A person said, "What they learn in the classroom is different to basic needs so they have to learn how I like to have things."
• Staff all confirmed they received training when they first started and certificates confirmed this. However, their opinion of the training varied and some did not feel it was sufficient. One staff member said, "I don't think it [training] was enough. We were only in there half a day. I think you need more training on equipment. I did do some shadowing though." Another staff member said, "The training needs improving." A new staff member said, "The induction was OK but could be a bit more thorough."
• Staff told us that some people could sometimes have behaviour that challenged them, however staff had not had any additional training about behaviours that challenge and ways to support people during this time. This left people and staff at risk.
• An operations manager had been recently employed and told us of the plans they had to improve training, so action was being taken to address this, but this had not yet been embedded.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law. Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Plans were not always in place to support people with their health conditions. Some people had health conditions that would mean there may be visual signs that they were becoming unwell. Some plans did not detail what these signs would be and staff did not have additional training in these areas, although the plan did tell staff to contact emergency services. However, this meant there was a risk people may not always be supported appropriately.
• Prior to starting to support people, the service would often get a plan from the local authority which detailed people's overall needs. This was then used, along with input from people and relatives, to develop a care plan for staff to follow. Some contained more detail than others, but the registered manager explained they were in the process of updating everyone's care plans.
• People were supported to access other health professionals. Staff were able to tell us how they would respond if there was an emergency situation. We saw referrals were made to other health professionals, such as district nurses and GPs.

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.
• We checked whether the service was working within the principles of the MCA, we saw that people were consenting to their own care. People had their capacity assessed when required and it had been recorded if anyone had a Lasting Power of Attorney (LPOA) in place. An LPOA gives people the legal right to make decisions on behalf of people who no longer have capacity. However, the evidence that the LPOA was in place had not been checked. Following our feedback, the registered manager told us they had requested evidence of LPOA.
• People did not raise any concerns about staff offering choices. Staff knew about mental capacity. One staff member said, "It's how a person can make decisions." Another staff member said, "It's their right [to make decisions]."

Supporting people to eat and drink enough with choice in a balanced diet
• People were supported to have enough to eat and drink. Many people were independent with preparing their food or had support from family members. However, we found that plans provided detail about how people needed to be supported and the staff documented in the care notes how they supported people and their food choices.
• Staff were able to describe how they supported people who needed additional encouragement to eat and some people or relatives confirmed they were supported well.

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; equality and diversity
• People's experience of being supported was impacted upon because systems were not always in place and effective at ensuring people had safe, effective, caring, responsive and well-led care.
• Relatives told us that staff did not always discuss appropriate subjects with them. One relative said, "Staff discuss other members of staff and the things they have done." This meant staff did not always observe confidentiality.
• People had some of their protected characteristics, such as gender preferences and religion considered. However, details were not always obvious in care plans and it was not evident that people were offered the opportunity to discuss their sexuality. It is important for people to be given this opportunity, should they choose to discuss it, as it may be important to them.
• Despite this, people and relative generally felt staff treated them with dignity and respect. One person told us, "Staff understand me and my needs. They offered to go get my food shopping. They will go out of their way. They sometimes work over the time." A relative said, "They [staff] are very friendly." Another relative said, "It's how the staff talk to [my relative], they are chatting" and they went on to say, "Staff are just all happy. They always greet us."

Supporting people to express their views and be involved in making decisions about their care
• People were not always involved in choices about their care. We were also given examples when people's call times were changed without discussing it with them. A staff member said, "They change times without checking with people." Another staff member told us, "For example, one person I go to likes to get up [at a certain time]. They've changed my call time. They'd just changed it without asking the person; they changed it half an hour."

Respecting and promoting people's privacy, dignity and independence
• People told us they were treated with respect, were helped to maintain their dignity and were helped to remain independent. One person said, "The support they offer to me, it's invaluable. They help with my independence, yes." A relative said, "They leave my relative for their privacy." One staff member said, "I encourage them if they can do things for themselves."
• All staff we spoke with could give us examples of how they supported people to maintain their dignity. For example, during personal care the door would be kept closed and people covered as much as possible. One staff member told us, "Whilst people are using the commode I leave them to keep their privacy and ask if they are ok."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same, requires improvement. This meant people's needs were not always met.

Personalised care
• When people had their regular staff, people told us they were supported in a way they liked. However, some people did not always have a consistent team of staff. A person told us, "I generally have the same staff – about eight to ten staff that come here over a week. They do have a high turnover of staff; you get used to the changes. I just wish the staff stayed." A relative told us, "You never seem to get the same ones [staff]. The rest keep changing, it can be anybody." They went on to tell us of two staff that visited regularly and they were particularly good, however they went on to say, "They send whoever they have available on the rota."
• When we discussed this with the registered manager, they explained, "We've done a big recruitment drive and making improvements which we are still working on." The registered manager and operations manager had recognised the need to try and retain staff had had recently increases wages and were implementing reward system for staff.
• People had personalised care plans in place. People and relatives confirmed they were involved in the developing of these plans. One relative said, "Yes [there is a care plan], they've been very good. I've had a few calls to check everything is ok." The registered manager explained they were in the process of updating everyone's care plans. We saw some plans contained information about people's life history and detail about how people liked to be supported with some in the process of being updated.

Improving care quality in response to complaints or concerns
• At the last inspection, we found improvements were needed to how complaints were dealt with. At this inspection, we found some improvements were still needed.
• People told us they felt able to complain, however there was mixed feedback about whether their concerns were responded to. Some people had responses, but others said it was inconsistent. One person said, "Yes, I've approached the [registered] manager about some concerns." When we asked them if their concerns were dealt with they said, "Sometimes yes, sometimes no. I wonder if the [registered] manager doesn't take action as its easier for them. I phoned and spoke to them, but they didn't call me back." They told us they still felt able to speak with the registered manager when they needed. The registered manager told us, "I follow the procedure needed to deal with concerns that are within the guidelines. I take action wherever necessary after enquiring about all factors that need to be addressed. For example, it is necessary to listen to all parties involved before acting on it."
• Recently, an operations manager had started who had involvement with complaints. This had ensured some improvements had been made since the last inspection. We saw complaints were discussed with the complainants and there were records of these discussions and measures put in place to resolve issues. However, there was no registered manager oversight of these to monitor trends and ensure learning was shared.

• The complaints information provided to people had contained an error and a lack of contact details, however this was rectified by the registered manager following feedback.

End of life care and support
• No one was imminently near the end of their life at the time of our inspection, so there were no plans we could view to check if these were appropriate.
• We discussed with the registered manager how they would support a person who was nearing the end of their life. They explained they would ensure a team of staff would be trained to support a person with their palliative care needs and would seek support from other local organisations with a specialisation in palliative care.

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 requires improvement. 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

• This was the fifth time the service had failed to achieve an overall good rating following a comprehensive inspection. Despite some improvements, some things had deteriorated or not enough improvement had been made. This showed the provider had not ensured regulatory requirements were always met, any improvements were sustained, and that people consistently received good care.

• Effective systems were not fully in place to monitor the quality of the service. Systems were not in place to have oversight of complaints, safeguarding concerns, medicine errors and the themes from audits carried out by senior staff. For example, there had been a serious medicine error. The correct action had been taken and measures put in place to reduce the risk of a reoccurrence. However, another medicine error was recorded in communication logs and this had not been identified or included in any monitoring or oversight of errors. This meant patterns or trends may not be identified to ensure improvements are made to the quality of care people received.

• Audits of care notes were completed by senior staff; however, these were not always being checked and the outcome of these was not always monitored so themes may not be identified.

• There was a lack of effective oversight of staff training. The training matrix had not been kept up to date and new starters had not been added on to monitor their training compliance. Staff all confirmed they received basic training when they started, but the majority felt improvements were needed.

• There was no monitoring of the call times staff were attending visits to ensure punctuality or that two staff were visiting at the same time, when necessary. This meant issues may not be identified. We found an instance that the times recorded in care notes did not always match the electronic logging in and out records, which meant an accurate record was not always being kept.

• Improved MAR charts had been introduced to help staff with recording of medicines. However, systems had failed to identify that topical medicines were being applied by staff but they were not always prescribed and were not always being recorded on medicine records. This meant there was a risk people were not always supported appropriately and consistently with their topical medicines.

• Improvements had been made to the office arrangements since our previous inspection. Paper records were being stored in the registered office address. However, we found improvements were needed to the storage of electronic data. Computers and memory sticks were not password protected or encrypted so there was the risk of information being lost and accessed by those not entitled to see the information. The registered manager had failed to recognise this as a risk. Following our feedback, passwords were added, and encrypted memory sticks were purchased to protect people's personal data.

The continued failure to achieve a good rating and above evidence constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The service was displaying their previous inspection rating in the registered office. However, they had failed to display this rating on their website, as required by law, although there was a link to the CQC website. Following our feedback, this was addressed and the rating was then displayed.
• Following our feedback, the registered manager told us of the improvements they planned to make and the action they took as a result of our findings. Other improvements were already in progress at the time of our inspection, such as an improved training programme and improved recruitment process. An electronic system was being introduced to record people's care which the registered manager explained would improve the oversight of incidents. Some staff we spoke with acknowledged work was ongoing to make improvements, one said, "We are working to get everything tip top."

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• The size of the service had expanded substantially following our last inspection, despite it being identified that improvements were needed to the service and quality of care being delivered to people. At this inspection we found that improvements were still needed, and some new areas of concern were found, as well as some improvements that had been made. A new operations manager and rota administrator had been employed to assist with the increase in the number of people being supported. However, this meant the registered manager had continued with taking on additional work, whilst improvements were still being embedded or had not yet happened so less-than-good care was being delivered to more people.
• When we asked the registered manager about duty of candour, they said, "If we do anything, we hold our hands up. We do an action plan." When something had gone wrong, the service had admitted it and taken action to protect the person effected. However, due to the lack of overall oversight of complaints, safeguarding, medicine errors, the issues arising from audits and other feedback there remained a risk the quality of care was not always improved.

Continuous learning and improving care
• Learning had not always been continuous and had not always resulted in improved care. The service had failed to fully act upon all improvements required that had been identified in competency checks and some areas had not always improved. Checks had spotted that staff did not always wear aprons. Feedback from people and relatives confirmed this was still an issue.
• Whilst there had been some learning from previous inspections as some improvements had been made, such as for the recruitment of staff and the filing of people's paper records, some governance systems were still not in place and further improvements were required.

Engaging and involving people using the service, the public and staff
• People were asked for their opinion about their care over the phone and through reviews of care. People knew they could contact the office for queries.
• Staff felt supported and felt positively about the registered manager and office staff. One staff member said, "I like them. You can have a laugh with them." Another staff member told us, "I absolutely feel supported. The flexibility with the team is superb. The manager is fantastic." Another staff member said, "The registered manager is good. They're really friendly. They're not like a boss, they're part of the team. They're approachable about anything and flexible with the carers."
• Staff explained that improvements had been made as they were having more regular team meetings and staff appreciation was being improved; staff had recently had a pay rise and additional rewards were being introduced such as vouchers as an incentive for good work.
• The care team, partially based in the office, had a positive impact on the service as some areas had been

more standardised; despite some improvements being needed for double up calls, rotas were more stable than previously. One staff member said, "Runs are pretty set. We are getting some set runs together. We're all a team, we all help each other."

Working in partnership with others

• The provider worked in partnership with other organisations and other health professionals. For example, they worked with social workers and other health professionals to support people.