Hartlepool Care Services Limited

Coastal Care North East Redcar and Cleveland

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Costal Care North East Redcar is a domiciliary care agency providing care to children, young adults and older adults in their own homes in the Redcar and Cleveland area. 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. At the time of inspection 50 people received personal care.

People's experience of using this service and what we found
Risk was not identified, monitored and reviewed safely. There were no protocols in place for complex risks to support staff to care for people safely. Medicines were not safely managed. Some staff lacked the necessary training they needed to care for people safely. A survey in September 2020 demonstrated people were happy with their care and the times of their calls. During inspection, people said they remained happy with their care, however did not receive their calls on time and some people said they did not have a choice about the staff involved in their care.

There was a lack of management oversight of the service. Limited quality assurance measures were in place and these were not effective in identifying where changes needed to be made. The Commission was not always notified of changes or incidents taking place. People and staff gave mixed reviews about communication from 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 20 February 2020). 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
This was a planned inspection based on the previous rating. We carried out an announced comprehensive inspection of this service on 20 February 2020, and breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

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

changed from requires improvement 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 Coastal Care North East Redcar on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We 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 people's care, medicines, safeguarding, training, leadership, quality assurance and oversight of the service. We also identified breaches in relation to changes and incidents taking place at the service which we were not notified about. In addition, the provider had failed to display their ratings from their previous inspection.

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

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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Coastal Care North East Redcar and Cleveland

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
One inspector and an Expert by Experience carried out this inspection. 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 houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 24 May 2021 and ended on 28 May 2021. We visited the office location on 24 May 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. We contacted Healthwatch for feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This

is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 12 people who used the service and two relatives about their experience of the care provided. We spoke with 11 members of staff including the registered manager, two directors, the care manager, a member of office staff, the training coordinator and five care staff. We reviewed a range of records. This included seven people's care records. We looked at six staff files in relation to recruitment and the training matrix for all staff. 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. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess and manage the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Risk assessments did not demonstrate how to manage or reduce risk. Risk assessments and support plans were not in place for some people's Care Act 2008 (Regulated Activities) Regulations 2014.
needs. This meant staff relied on their knowledge of people to keep them safe.
- Protocols were not in place for staff to support people with key risks, nor were there any specific protocols in place for children. Support was not in place for staff working in high risk situations. Guidance was not in place for staff to provide people with adapted diets. We could not be sure if people were provided with food at the right consistency to manage their risk of choking. Staff had not received training to provide people with adapted diets.

Failure to manage the risk of harm to people has led to a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At the last two inspections the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Gaps in people's medicine records continued. Where medicines were not given, reasons for this decision making were not always recorded. Due to the level of missing signatures, it was difficult to determine if people had actually received their medication as prescribed.
- Protocols to support 'when required' medicines had still not been put in place. There was a lack of guidance in place to support staff to give these types of medicines to people. Some 'when required' medicines were given routinely.
- Some topical creams were not applied as prescribed. Some medicines could not be given as prescribed. This was because there was not enough time between calls to allow staff to give people their medicine

safely."

Failure to safely manage medicines had led to a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Some people said they did not have a choice about the staff involved in their care. Staff responsible for overseeing care staff had not identified potential safeguarding concerns. For example, there had been repeated incidents where medicines could not be given because there had not been enough time between doses. We raised safeguarding alerts for the people involved in these concerns.
● Staff had received training in safeguarding adults. Staff who supported children had not received training in safeguarding children. The provider addressed this following feedback.

The systems in place did not always safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People said they felt safe when staff supported them. Comments included, "They [staff] are very kind to me" and "Anything I tell the girls, they will do it for me. The carers are excellent." A relative said, "I have every confidence in them."

Learning lessons when things go wrong
● Incidents were not robustly monitored. Care plans were not updated when incidents took place. Records to learn lessons were in place but had not been completed.
● There was no evidence that lessons had been learned since the last inspection. The risk of harm to people had increased. The provider has not taken action to ensure people received safe care.

Lessons had not been learned. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People said calls were either late or early, some people said their calls were rushed. One comment included, "You get a rota to say what time they [staff] are coming and they are always early or later than the times supplied on the rota. They don't let me know; they don't tell me they are going to change my carers either." Staff consistently said there was not enough travel times between calls.
● People gave mixed reviews about the consistency of carers. Some people had the same carers and said, "I have the same carers in" and, "I have one regular carer." Other people said, "I don't get the same one [carer for each visit]. I get very nervous if I have a different one. There are no introductions [to a new carer]." A director said they did try to give people consistent staff.
● Staff did not have training in safeguarding children, diabetes, skin integrity and the Mental Capacity Act. Training for some staff in areas such as health and safety and dementia were not up to date. Training for leaders at the service was out of date or not completed. A director told us about the difficulties they had experienced during the pandemic. They were now taking action to ensure training was up to date for all staff.

Effective systems were not in place to manage staffing. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were continued gaps in recruitment records which had not been addressed. Gaps in employment history were not explored during the recruitment process. Quality assurance checks had not addressed these omissions.

Continued gaps in recruitment records has led to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Government guidance for managing the risks associated with the Covid-19 pandemic were not followed in the office. For example, social distancing was not maintained because too many people were congregated together. Non-essential visits to the office had not been discouraged. The provider took action to address these concerns following feedback.

Failure to follow government guidance to manage the risk of infection has led to a breach of regulation 17 (Good governance) of the Health and Social

● People said staff wore PPE during their care calls. Staff said they had enough supplies of PPE.

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; Continuous learning and improving care

At the last two inspections the provider had failed to ensure a robust system was in place to monitor the quality and effectiveness of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Limited audits were in place to monitor the quality of the service. Audits had not been effective in identifying any of the concerns found during inspection. Quality assurance measures were not effective in identifying where improvements needed to be made or if feedback from professionals had been addressed.
● Improvements had not been made following the last inspection. The service has been in breach of regulations since 2018. Action plans provided to the Commission following the previous inspection had not been addressed.

The quality of the service had not been addressed. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had invested in new IT and quality monitoring systems to support the delivery of care at the service. A director told us about how these had been successfully trialled in another of their services and these would be embedded into this service. Staff continued to be kept up to date with changes taking place at the service.

● The provider did not tell the Commission by way of notification that they moved address on 6 April 2021.

Failure to submit a notification is a breach of regulation 15 Care Quality Commission (Registration) Regulations 2009.

● The provider did not display the rating of the last inspection on their website or in the office location.

Failure to display ratings is a breach of regulation 20A Care Quality Commission (Registration) Regulations 2009.

● The Commission was not always notified when people died.

Failure to submit notifications relating to death is a breach of regulation 16 Care Quality Commission (Registration) Regulations 2009.

● The Commission was not always notified when safeguarding incidents took place at the service.

Failure to submit notifications relating to safeguarding incidents is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 registered manager was not involved in the day to day running of the service and did not have sufficient oversight of the service. Staff responsible for the day to day running lacked the knowledge and skills needed to deliver safe care to people. There was a lack of understanding of risk. Staff said they raised concerns about people which were not addressed.
● Staff gave mixed reviews about support in place for them. Some staff said they had been listened to and their feedback addressed. Other staff said there was a lack of confidentiality and they would not raise a concern. Staff raised concerns about how they were spoken to from the office. People, staff and professionals said communication from the office needed to be improved.

Leaders were not effective in maintaining the quality of the service. This was 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
● People said they did not like to ring the office. Their calls were not always returned and they did not find contact with them helpful. Comments included, "I ring them up as a last resort" "I don't feel comfortable [ringing the office], there always seems to be an issue" and "They are not helpful, nothing gets done."
● People told us they did not like to give feedback. One comment included, "I am careful what I put because my name is at the top. Having your name on top of the paper is wrong." Feedback from professionals had not always been addressed.

These concerns identified a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did seek feedback from people. In the latest survey, dated September 2020 the responses were largely positive. During the Covid-19 pandemic a professional did provide positive feedback to the manager about how accommodating the service was in talking on a new package of care.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (1) People were not safeguarded from the risk of abuse.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18 (1) and (2) People did not receive their calls on time and were not consistently made aware of changes to their calls. Staff training was not up to date.

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 15 Registration Regulations 2009 Notifications – notices of change (1) The provider did not notify the Commission about a change of address.

The enforcement action we took:
No further action was taken.

Regulated activity	Regulation
Personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services (1) The provider did not submit notifications to the Commission when people died.

The enforcement action we took:
No further action was taken.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents (1) The provider did not notify the Commission when safeguarding incidents took place.

The enforcement action we took:
NO further action was taken.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) People did not receive safe care.

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1) Quality assurance procedures were not

	effective. There was a lack of oversight of the service.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments 20 (A) (1) ratings were not displayed on the providers website or in their office location.

The enforcement action we took:

No further action was taken.