Careworld London Limited

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Inspection report

The Whitechapel Centre
85 Myrdle Street
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Date of inspection visit:
21 August 2018
22 August 2018
23 August 2018
29 August 2018

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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

We undertook an unannounced focused inspection of Careworld London Limited on 21,22, 23 and 29 August 2018. At the previous comprehensive inspection in October 2016 the service was rated as Good. We inspected the service against two of the five questions we ask about services: is the service safe and is the service well- led?

No risks or concerns were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older adults, younger disabled adults and children. At the time of the inspection they were supporting 348 people in the London Boroughs of Hackney, Tower Hamlets and Newham. Not everyone using Careworld London Limited receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The provider did not have appropriate policies and procedures in place to ensure that people received their medicines safely and effectively. People's records were not always clear as to what support they received with their medicines and audits did not pick up the issues we found at the inspection.

People who lived with specific health conditions did not always have the risks associated with these conditions assessed and information in care plans was not always accurate to ensure their safety and welfare. Risk assessments did not always provide staff with guidance on how to minimise risk.

Although there were quality monitoring systems in place, they were not always effective in picking up the issues we found during the inspection and improving the quality of the service. Information was not always up to date, accurate or checked to ensure people's needs were met. The size of the service had increased dramatically since the previous inspection in October 2016 due to the provider securing local authority contracts. The provider acknowledged this had been a factor in the concerns received.

Learning had been shared across the organisation in response to a serious incident that occurred in March 2018. The provider acknowledged improvements were needed and had been proactive in updating and reviewing their policies and procedures. Staff we spoke with were aware of the action that had been taken in relation to this incident and knew how to respond in similar circumstances.

Safeguarding investigations that had been carried out were not always recorded accurately or were clear about the response to the concerns and what the outcome was. The safeguarding log was disorganised with supporting documents relevant to the investigation either unavailable or stored in separate files. Actions from safeguarding meetings had not always been followed.

People and their relatives told us they felt safe using the service and were comfortable approaching the management team if they had any concerns. Staff spoke positively about the management of the service and levels of support they received.

The provider did not meet the CQC registration requirements regarding the submission of notifications about serious incidents, for which they have a legal obligation to do so.

We found three breaches of regulations in relation to safe care and treatment, good governance and notifiable incidents. You can see what action we told the provider to take at the end of the full version of this report. We also requested an action plan and for the provider to send us monthly updates on how they are making improvements to the service.

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.

Appropriate policies and procedures were not in place to ensure people received their medicines safely and effectively.

Risk assessments were in place but lacked sufficient detail about the care and support needed to reduce the likelihood of people coming to harm. There was contradictory information within people's records and further guidance was needed for staff to follow.

Staff had a good understanding of how to recognise and report any signs of abuse and protect people from harm. Action had been taken to improve how failed visits were managed and there had been learning across the organisation.

Safeguarding investigations were not always clearly documented about what actions had been taken and what the outcome was. Actions from safeguarding meetings had not always been followed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider failed to meet their legal requirements to inform the Care Quality Commission of notifiable incidents.

Although there were quality monitoring checks being carried out, there was not a fully effective system in place to check the records of the care and treatment that people received.

People and their relatives were positive about the service and felt it was well managed. Staff spoke highly of the working environment and the support they received, including opportunities for progression within the organisation.

The provider's most recent annual survey showed people were happy with the care and support they received.

Careworld London Limited

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.

The inspection was prompted in part by a notification of an incident following which a person using the service died. This incident is still under investigation by the local authority but we followed up the action that had been taken in response to the outcome of the coroner's inquest to ensure the risk had been mitigated. We also received anonymous information of concern between December 2017 and July 2018 in relation to quality concerns, missed visits and care workers not staying the full amount of time. We had shared this with the local authorities and followed this up at the inspection. A local authority had also terminated one of their large contracts and told us it was due to an increase in the number of quality concerns.

The inspection took place on 21, 22, 23 and 29 August 2018 and was unannounced. The provider was aware that we would be returning after the first day. The inspection was carried out by three inspectors and one medicines inspector. The team also included three experts by experience who were responsible for contacting people and their relatives during the inspection to find out about their experiences of using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Inspection site visit activity started on 21 August and ended on 10 September 2018. We visited the office location on 21, 22, 23 and 29 August 2018 to see the registered manager and office staff and to review care records and policies and procedures. Following the site visit we made calls to care workers and health and social care professionals.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report. We also spoke with the local authority safeguarding teams and commissioning and contract monitoring teams and used their feedback to inform our planning.

We called 75 people using the service and managed to speak with 16 of them and 22 relatives. We spoke with 21 staff members. This included the registered manager, the head of operations, the branch manager, the care coordinator manager, a team leader, a care coordinator, an electronic call monitoring officer, the trainer and the human resources manager. We contacted 28 care workers and spoke with 12 of them. We looked at 28 people's care plans, 16 staff recruitment files and audits and records related to the management of the service.

Following the inspection we spoke with five health and social care professionals who worked with people using the service for their views and feedback.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection, the provider was not supporting people with their medicines. During this inspection we could not be assured that people received their medicines safely. The provider's medicines policy stated that for people who were supported with their medicines, staff must ensure that there is a list of medicines that the person is taking. It should include the name, strength, form, dose, timing, frequency and the reason for why it is taken. However, we found that the provider was not following their own policies and procedures as a number of people's care records did not include information about the medicines they were taking.

One person's assessment said that care workers should assist them with their medicines and record the outcome in the daily logs and in the medicine administration record (MAR) chart. Daily logs confirmed they were being supported with their medicines but their list of medicines had not been recorded and there were no MAR charts in place. For another person, there was conflicting information about the level of support they received and what medicines they were supported with. One part of their care plan stated that their diabetes was tablet controlled, however another page recorded insulin was needed four times a day, with no further information recorded. Their assessment stated a relative was responsible for administering their medicines, however the care plan stated care workers were responsible for their medicines during the morning visit. There were no MAR charts available and no written records in the daily logs to confirm if they had been supported with their medicines.

MAR charts were not available for all the records we reviewed so we could not be assured that people had received their correct medicines, at the correct time. For the records we were able to view, although we saw one person had a recently updated MAR chart which included the list of medicines they were taking, we found concerns with how they had been recorded. For one person, there were gaps in signing the MAR chart from 11 July to 19 July 2018. There was no record to explain this reason or if it had been followed up. This person's MAR chart for June 2018 had also been signed by the same care worker for each day of the month. We reviewed the daily logs for this period which showed that different care workers had visited and recorded they had administered medicines. We checked the rota and electronic call monitoring (ECM) data which confirmed this member of staff had not worked every day in the month. Another person's MAR chart for June 2018 was blank in the section where medicines should be recorded. Despite this, the MAR chart had still been signed even though no medicines information was available. The head of operations acknowledged this and that improvements needed to be made. The trainer added that they were aware of this issue and were in the process of making medicines training more inclusive and accessible to care workers where English was not their first language.

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

Initial assessments were completed by the agency to identify any potential risks associated with providing people's care and support. The risk assessment covered areas which included people's specific health conditions, mobility, finances, nutrition, medicines and cognition. The agency also carried out an

assessment on the person's home environment. Although risk assessments were in place they lacked detail and important information about people's care and there were inconsistencies in the records we reviewed. We found that people's records did not always reflect the current level of care being provided.

One person needed to use oxygen twice a day to manage a health condition but there was no information within their care plan about how this was managed. The environmental risk assessment recorded that the home was cluttered and escape routes were obstructed. There was no record to show if this had been followed up to reduce the risk. The person was also a smoker and this risk had not been assessed in relation to the use of oxygen. It had not been recorded in the fire risk assessment. Insufficient action had been taken to mitigate this risk which placed the person and the care workers at risk of potential harm from fire. We shared guidance with the provider from the London Fire Brigade (LFB) in relation to home risk assessments on the second morning of the inspection.

Another person was living with advanced dementia and their local authority assessment highlighted that they exhibited behaviour that challenged the service, including scratching, biting and hitting care workers. This information was not recorded in their care plan and there was no further information or guidance for care workers to follow to manage the risk. This person was also living with diabetes and their care plan stated to follow a diabetic routine. However, there was no further information about the risks related to their condition or any guidance for care workers to follow in the event of their health deteriorating. A third person was at risk of falls due to their reduced mobility. However, there was contradictory information within their records as their moving and assistance assessment stated they were independent and able to weight bear, but it added the need for a hoist and the support of two care workers to ensure safe transfers. We addressed these issues with the management team who acknowledged records needed to be improved. The head of operations added, "We are currently reviewing all care plans as we have noticed issues within them and need to carry them out in much more detail."

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

We followed up an incident that had occurred in March 2018 where a person using the service had died. The outcome from the coroner's inquest highlighted there was a risk that future deaths could occur unless action was taken. This related to improvements that needed to be made into how their 'No Response' policy was understood and followed. We discussed in detail with all the members of staff we spoke with during this inspection about the incident and what lessons had been learnt. We saw that the provider had shared this across the organisation and the policy had been reviewed in July 2018 which made procedures to follow much clearer. An action plan had been implemented where all key holder information and emergency contact numbers had been updated, with all staff to be retrained on safeguarding and the failed visit procedure. The head of operations said, "It was an eye opener for us and we have certainly learnt from it and want to do whatever we can to ensure that it doesn't happen again."

All of the staff we spoke with were able to explain the updated policy and what their responsibilities were if this scenario occurred. Comments included, "It was a big learning point for us and we've learnt from the mistakes we made. We have taken action and it has been discussed in meetings", "We have to call the office and wait for further instructions. It has also been discussed during supervision and team meetings" and "I look through the windows and letterbox and also try and contact the neighbour. I have to stay at their home until I hear from the office. We now have a form that we can put through their door."

People we spoke with told us that they felt safe when receiving care. Comments included, "When they come in, they make me feel safe, especially when in the shower and giving me general care", "I do feel safe yes.

[Care worker] can be trusted if I give her money to buy me things from the shop, she always gives me my receipt and change" and "Absolutely safe. I rely on them and both of the carers are very good." Relatives added, "We feel very safe with the support provided. They've built up trust which gives me peace of mind" and "I have no concerns, they can be trusted if they do the shopping and nothing has gone missing."

The branch manager was responsible for carrying out investigations into any concerns received. Staff we spoke with were confident that any concerns reported would be dealt with immediately. However, we found that the safeguarding investigation log was disorganised and investigation records did not always record what action had been taken and what the outcome was. Supporting documents related to investigations, such as statements, meeting minutes and email correspondence were not always readily available when reviewing the records. We found one incident related to an allegation of missed visits and daily logs being completed in advance that had not been fully investigated, which was acknowledged by the branch manager. We also found that actions resulting from safeguarding meetings, such as weekly monitoring checks to be put in place, had not always been followed. The head of operations acknowledged that their investigations and recordings were not comprehensive enough and needed improvement.

At the time of our inspection the provider had approximately 290 care workers employed in the service, with 195 active and the remaining either bank staff or those previously supporting people who had recently been transferred. The majority of people spoke positively about the punctuality of their care workers and stated that they stayed the full visit. Comments included, "They always come at the regular time and stay the full time" and "The carer is never late, no calls are missed. They send replacements to cover sickness and holidays." One relative told us that there were no issues with their regular care worker, but one that covered had been late on a couple of occasions without letting them know. Another relative told us that the care worker came at inconsistent times for the morning visit. We reviewed the electronic call monitoring (ECM) information for the week commencing 20 August 2018 and saw there was a vast difference in the time for the scheduled visit to the actual visit. The morning visit was scheduled for 9.00am. We saw the care worker arrived at 10.24am on Monday, 07.24am on Tuesday, 08.32am on Wednesday, 09.31am on Thursday and 08.19am on Friday. We also found for another person that needed the support of two care workers at a time, it was common for care workers to arrive much later for the 4.00pm afternoon visit, between 5.00pm and 5.30pm, and then much earlier for the 8.00pm evening call, around 7.00pm. On one occasion, both care workers logged out of the afternoon call at 5.35pm, but logged in for the evening call at 5.40pm. This meant that there was a shorter time between visits and the person had to wait longer for the morning visit the following day. We raised these issues with the head of operations who told us they would look into it.

Care workers told us they were happy with their rotas, that calls were based within their geographical area and they generally had enough time to get to their calls on time. One care worker said, "I have time to travel between visits and it is mandatory for us to log in and out of calls so they can see that we are there. We've had meetings about it and how it works. I like it as it shows we are on time." ECM was still in the process of being fully implemented at the time of the inspection. It had started on 6 August 2018 and at the time of the inspection approximately 80% of the Newham contract was being electronically monitored, with it expected to be completed by the first week of September 2018. A health and social care professional contacted us after the inspection to let us know that the Newham compliance rate for the month of August 2018 was just over 75%, which they were much happier with. There was no ECM in place for people managed under the Hackney contract and this was scheduled to be completed by 17 September 2018. At the request of the local authority, the provider was making calls to people, their relatives or care workers to confirm that visits had been made until ECM was fully in place. We saw a matrix had been created which confirmed this was taking place.

We saw that staff were reminded of their responsibilities to ensure infection control procedures were

followed. Care plans had a cleanliness and infection control assessment in place and highlighted the importance of following guidelines. This included wearing personal protective equipment (PPE), such as gloves and aprons when supporting people with personal care or when preparing food, and changing them between care tasks. One care worker said, "We have had the training and I'm aware of the importance of minimising the risk of cross infection. PPE is always available and everything we need we can pick up from the office."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. Our records showed he had been formally registered with the Care Quality Commission (CQC) in April 2012. The branch manager was also in the process of applying to be a registered manager and had submitted their application during the inspection. They were both present on each day and assisted with the inspection, along with the head of operations.

The registered provider is required by law to promptly notify the CQC of important events which occur within the service. We found that not all safeguarding incidents or incidents involving the police had been notified to us. Notifications that had been submitted were not always done in a timely manner. For example, one incident occurred in March 2018 but we were not notified until June 2018. For another safeguarding incident a social worker requested confirmation in an email dated 16 February 2018 that the incident had been reported to the CQC, but the notification was not submitted until 23 March 2018. The provider acknowledged this oversight and agreed to submit notifications for the incidents that we had found after the inspection.

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

At the last inspection in October 2016 the provider was supporting 68 people. Since then, the provider had been successful with securing local authority contracts and the service size had increased dramatically to 667 people as of 25 July 2018. In August 2018 the London Borough of Tower Hamlets terminated one of their contracts and 325 people were transferred to other care agencies by 20 August 2018. The provider told us that the speed in which the service increased had been overwhelming and had been a factor in the increase in quality concerns and the issues we found during the inspection. The provider told us that they were still in the process of appealing the decision for their contract being terminated.

Although there were quality assurance systems in place to monitor the service, we found that auditing and monitoring systems had not always identified, addressed or managed the shortfalls we found during the inspection. People's care documentation was also not always an up to date or an accurate record of their needs and how these were to be met.

At the time of the inspection the auditing of people's daily logs, medicine administration record (MAR) charts and financial records was not always being done to make sure staff were following the provider's own policies and procedures. For one person's MAR chart that had been returned, we found that there were gaps with no further information to explain the reason why. Another MAR chart had been signed by the same staff member for each day of the month, which we found was not a true record of the support the person had received. Medicines audits consisted of a member of staff ticking the MAR chart at the end of each month. Both MAR charts had been audited, however these inconsistencies had not been identified.

One person was being supported with their finances and the provider was responsible for holding their bank cards and managing their money on the person's behalf. There was no information recorded in their care

plan and it stated the person managed their finances independently, which was inaccurate. There were no guidelines in place for staff to follow and we found discrepancies within the monthly financial record log. The head of operations acknowledged this and confirmed that the monthly log had not been audited. Further checks found that a staff member had been using their own store loyalty card when carrying out the shopping for this person. This had also not been picked up when checks were carried out. We asked the head of operations to inform us of the action they would take in response to this on 29 August 2018 but have not yet received a response.

We viewed samples of the daily logs and saw that they had not been checked to ensure the correct level of care was being carried out. Information in one person's daily logs was illegible and we could not ascertain the level of care and support that had been carried out. Care worker entries recorded the person was being massaged, but this was not recorded in the care plan. Another person's daily logs had the same recorded entry for each visit from 29 May to 31 July 2018. A third person's daily logs did not have an accurate account of each visit. Care workers had recorded, 'do as same' or 'as above' for a number of visits. These issues had not been picked up when the log books were returned to the office. We spoke to the head of operations about this who acknowledged that improvements needed to be made. They added, "The daily logs are in the process of being reviewed. We are enforcing day in and day out for care workers that they must realise that it is important to evidence what they have done."

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

Informal management meetings took place on a weekly basis to discuss any issues that arose from the on-call report and what action needed to take place. We saw minutes from the most recent quarterly management review meeting that took place in May 2018. We saw that it covered safeguarding concerns, transfer of packages, managing care staff competencies and quality monitoring. It also covered the serious incident related to the provider not following the No Reply policy. We saw learning had been taken from this incident and the meeting discussed how this would be shared across the organisation to ensure all staff understood the seriousness of not getting a response from people they supported.

Staff meetings were held monthly and scheduled throughout the month and at different times across the day to ensure as many care workers could attend as possible. We saw the serious incident had been discussed with information about the guidelines to follow in these circumstances. We saw that topics discussed included communication, logging in and out of calls, care worker responsibilities in relation to medicines and a range of policies and procedures. One member of staff said, "We have regular meetings which are good and they communicate with us well. It is good there are different slots to work around our schedule. We also get regular updates via text messages, with reminders about our jobs."

The quality monitoring system in place showed that quarterly spot checks and monthly telephone checks were in place, which were the responsibility of the team leaders and care coordinators. Comments from people included, "Somebody calls me every month and they physically visit every three", "[Staff member] from the office called two weeks ago to ask if everything is OK and they do listen to us" and "Somebody came to visit me about a month ago. I think it is well managed." Care workers we spoke with confirmed this and were positive about the unannounced checks they received. One care worker said, "Sometimes, they just turn up unannounced. The team leaders come out and check the documents to see what we are writing down." Another care worker said, "We do get them regularly. It is good that they look at the punctuality and the safety of the service."

People using the service and their relatives spoke positively about how the service was managed and the

support they received. Comments included, "I think the service is well managed. I am very happy and they always ask if I need any improvements", "I feel comfortable talking to them and they put me at ease. They call me every few weeks to see how I'm doing", "They are easy to contact and very responsive" and "Yes, it is well managed. I would rate the service 9 out of 10, you can't really fault it, but there are always ways to improve." One relative told us that they had never been let down by the service. They added, "I can't think of any service improvements, I have no concerns and my [family member] is happy." Two health and social care professionals we spoke with were positive about the working relationship they had with the provider and felt the service was proactive in responding to requests and tried their best to accommodate people's needs. One of them added that they felt the provider went out of their way at times to respond to urgent requests.

All of the staff we spoke with told us they felt well supported in their roles and we received positive feedback about the management of the service and the welcoming office environment. Comments included, "I'm happy working here. The office team are friendly and approachable and the communication is good", "They have always been very helpful, flexible, understanding and supportive", "They are very accommodating, helpful and always willing to listen to me. I've never had a problem in two and a half years" and "We work as a team, it is a good environment and they motivate me to do my job." Staff spoke positively about the registered manager and management team. One member of staff said, "They have been supportive from day one. The support they have given me has made me feel comfortable working here." Only one member of staff highlighted a negative aspect of the service, which they felt related to office staff needing to act faster to information given from care workers.

Staff also told us that the provider had given them opportunities to progress within the organisation and were supported with their personal learning and development. Two care workers told us how they were being supported to study further vocational qualifications within health and social care. One of them added, "Being supported with my level three qualification has given me confidence and helped me to improve." Another member of staff said, "It is a great company to work for. I started as a care worker and I feel the sky is the limit with the opportunities available. I'm proud to work here."

We saw the provider's most recent annual survey report that had been completed in April 2018. 321 people were sent a survey and records showed they had received 172 responses. The majority of respondents were positive about the service they received. For example, 100% of respondents felt their needs were met, felt they were respected and felt staff promoted their health and safety. 99% felt encouraged to be involved in their care planning and 95% felt their care plans contained adequate information about their needs. Finally, 91% felt safeguarded with the systems in place when they were supported with their finances.

At the time of the inspection we found that the provider was not displaying their current CQC rating on their website in line with our required guidance. The registered manager acknowledged this and told us that their website was currently being updated. We requested that it was done as soon as possible and had been updated by the end of the inspection.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents. The registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18 (1), (2) (a) (ii) (iii) (b) (e) (f)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that risks to the health and safety of service users were regularly assessed and did not do all that was practicable to mitigate any such risks. Regulation 12(1)(2)(a),(b) The provider did not ensure that care and treatment was provided in a safe way as systems for the proper and safe management of medicines were not operated effectively. Regulation 12(1),(2)(g)

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure systems or processes were in place to assess, monitor and mitigate the risks relating to the health , safety and welfare of service users. the provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided. Regulation 17(2)(b)(c)

The enforcement action we took:

We served a warning notice.