Carby Community Care Ltd

Carby Community Care

Inspection report

60 Beckenham Hill Road
London
SE6 3NX

Date of inspection visit:
22 May 2019
23 May 2019
24 May 2019

Date of publication:
15 July 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Carby Community Care is a domiciliary care agency that provides personal care to people living in their own homes. It provides a service to older people and younger adults with disabilities. At the time of our inspection they were supporting 67 people. 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's experience of using this service:
People and their relatives told us they felt safe and spoke highly of their regular care workers. People told us, "The carers are very good, very caring" and "I couldn't wish for a better carer". However, medicines were not always managed safely and audits did not identify serious issues with medicine administration records.

People were looked after by staff who understood their safeguarding role and responsibilities. The manager dealt appropriately with safeguarding concerns.

Most of the people we spoke with were being visited around their preferred time by regular care workers, but some of those also said the service was unreliable when their usual staff were not available. People and staff told us the office did not communicate changes in the service well. A person told us, "They should be more efficient." Rotas issued to staff did not always reflect the real order in which staff visited people.

The provider was making significant progress in improving some aspects of the service, such as the safe provision of visits that required two care workers to attend and in the prompt recruitment of a new manager and other staff. The morale of care workers was variable, although new staff gave positive feedback about their recruitment and training. The practice of fining care staff for absence and errors in medicines recording presented potential risk to people.

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.

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

Rating at last inspection: The last rating for this service was Good (published 31 August 2017).

Why we inspected:
The inspection was prompted in part due to concerns received about unsafe medicines management, recruitment, call times, visits that required two care workers only being attended by one, staff morale and the governance of the service. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Carby Community Care on our website at www.cqc.org.uk.

Enforcement:
We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment, specifically around the management of medicines. Please see the action we have told the provider to take at the end of the report.

Follow up:
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Carby Community Care

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 team consisted of 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.

It is a condition of the provider's registration to have a registered manager in post. This is to make sure they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was no registered manager in place at the time of the inspection. A new manager had been recruited but was brand new in post at the time of the inspection and so was not yet registered with us.

Notice of inspection:
This inspection was unannounced.

Inspection activity started on 22 May 2019 and ended on 17 June 2019. We visited the office location on 22, 23 and 24 May 2019 to see the manager and office staff and to review records.

What we did before inspection
We reviewed all the information we held about the service, including notifications sent to us about key events and incidents which the provider is required to send to us. We gathered information from other sources including the local authority contract compliance and safeguarding teams.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with 13 members of staff including the provider, the newly recruited manager, the acting manager and nine care workers.

We reviewed a range of records. This included seven care records, one record for a person who had recently stopped using the service, medicines records and audits, records of complaints and safeguarding concerns. We looked at four staff files and training documents. A variety of records relating to the management of the service, including policies and procedures were reviewed. We reviewed information and records the provider has given us to evidence the action they are taking to improve the service.

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 Good. At this inspection this key question has now deteriorated to 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.

Using medicines safely

● Medicines were not always managed safely. Accurate records were not being kept. We looked at several medicine administration records (MAR) and found concerning errors and omissions. We highlighted these concerns and the provider spoke with the people and staff involved to establish if people were at risk. This uncovered further issues around the accuracy of the records, such as people signing for warfarin they had not actually given. A relative told us they had had issues with staff failing to correctly manage their family member's warfarin.

● Audits had been introduced of returned MAR charts. There was a persistent issue with staff missing days on the MAR charts, which was identified in the audit, but these had failed to identify further serious issues. This included undated and unclear records, apparent extra doses for several days at a time and medicines being signed for as given that were not identified. Amendments had been made to information on the charts with no record of who had done this or why. There were no current lists of people's medicines on file at the office to compare the MAR charts to when auditing.

● The management team had undertaken observations and re-training of staff who had been making errors in medicines management. We reviewed the medicines component of the induction training and found out of date information.

● The provider had instituted fines for staff who were making errors in their recording of medicines. We saw in the MAR audits that several members of staff were to be fined as a result of their failure to keep good records. This presents the risk that care workers, to avoid a fine which would significantly affect their wages, might fail to report mistakes they had made or might make inaccurate entries in the records to cover up a mistake.

● People's risk assessments and support plans around medicines were not always clear, which put them at risk of getting the wrong medicine or not being given medicine they needed. We saw examples of contradictory information about the level of support a person required, and several examples where a question about consent to accept support with medicines had apparently been misunderstood by the assessor.

● Care staff were administering medicines that were not part of the support plan and that the office were not aware of. We saw on a person's daily care notes that the care worker had applied a "medicine patch" but this was not on their MAR and there was no information about what the patch was for. Care workers had also collected medicines for the same person from the pharmacy when this was not on the support plan.

The failure to ensure the safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed with the district nurses that the people on warfarin were not at risk, and updated the MAR audit form to include more prompts and a checklist. The provider was aware of many of the issues identified and told us they are reviewing this area as a matter of urgency, using best practice guidelines and guidance from external sources.

Staffing and recruitment

● People praised their regular care workers. Several people and relatives commented that there was a high turnover of staff. People told us, "I've got one lady who comes to me, she is terrific, but when they send other people, they aren't as good" and "The other staff tend to come and go."

● Prior to this inspection, we had received complaints from people's relatives around the timing of their family member's visits. We had also received information from whistleblowers indicating that they were unable to complete their visits as scheduled, potentially putting people at risk if their visits were time sensitive. Although people told us care workers usually stayed for their allotted time and completed their required tasks, the timing was still an issue for some people. Relatives told us, "The timekeeping is dreadful… I have to phone and see where they are, they rarely phone" and "The main thing is changing his pad so if they are too late it's really bad for him to sit in it all night."

● People and relatives told us sometimes only one care worker had attended visits that were scheduled for two members of staff. This was an issue which had been identified by the provider and was part of their action plan. Action had been taken to improve the situation and we could see a marked improvement in the electronic call monitoring (ECM) records for people who needed support from two care workers.

● We spoke with current staff about their schedules and reviewed the rotas for the week prior to our inspection visit. Staff told us their rotas were not always practical and we saw examples of rotas with insufficient travel time. Reviewing the ECM records, we saw that the staff members with impractical rotas were not sticking to them and were attending visits out of order, with the agreement of the people they were visiting. A care worker told us, "There is a lot of back and forth on my rota, but because I know my clients and the times they like, I do it that way." A relative told us, "They are sent all over the place, it's not right."

● The service made appropriate checks made to ensure people were protected from the employment of unsuitable staff. Disclosure and Barring Service (DBS) checks for all staff had been completed and a DBS tracker was in place. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care services. However, some staff had gaps in their employment histories and references had not always been verified by the provider.

Systems and processes to safeguard people from the risk of abuse

● People told us they usually felt safe. One person told us, "Yes, I definitely feel safe."

● People were cared for by staff who were aware of the signs of potential abuse. Care staff we spoke with confirmed they had received training in safeguarding adults during their induction although this training was not refreshed regularly. Staff told us they were confident that any concerns they raised would be taken seriously by the manager. One said, "They sort things out, anything needs changing they do it."

Assessing risk, safety monitoring and management

● Risks to people were identified and measures put in place to minimise these risks. Risk assessments we looked at had been completed in detail and were recently reviewed. A staff member told us, "The risk assessments are useful." Another said, "I have all the information I need."

● The fire risk assessments were detailed and based on guidance issued by the London Fire Brigade (LFB). We saw an example of a person who had been referred to the LFB for a home fire safety visit as a result of their recent review.

Preventing and controlling infection

● The service had infection control policies and procedures in place, and staff told us they had a plentiful supply of personal protective equipment (PPE).

● People told us their care workers usually tidied up and disposed of rubbish appropriately.

● Three care workers told us they had been fined for having to take time off work due to sickness, even when their sickness presented a risk to the people they visited, such as when they had vomiting and diarrhoea. We advised the provider about this, and she said this was possibly a misuse of the fines system under the previous manager and she would investigate. However, even when used in line with the provider's policy this presents the risk that, to avoid a fine, staff might go to work when they are contagious with illnesses that present a risk to the people that they visit.

Learning lessons when things go wrong

● Staff understood their responsibilities to raise concerns and report near-misses. Learning from these had been shared with staff through meetings and WhatsApp staff group messages appropriately.

● The service had drawn up an action plan for the local authority in response to concerns identified by the contract monitoring team. This had identified many of the issues we identified during the inspection.

● A further detailed and realistic action plan had been drawn up by the provider in response to the initial feedback they received at the end of our visit, and they have sent evidence to show improvements made.

Requires Improvement

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The current management and co-ordination team were committed to providing good care. Staff were person-centred in their approach and people told us their regular care workers provided high-quality care. A relative told us, "There are carers who stand out as doing that little bit extra." Staff told us, "I'm most proud of seeing the changes in my clients, when people get healthy with our help" and "It makes me proud when my clients are happy." However, although the situation was stable there had been a high turnover of staff and feedback from people reflected this. A person told us, "We've seen seven different staff in the last few months, they leave and go somewhere else."
- Staff morale was variable. Some of the staff we spoke with during the inspection expressed unhappiness with the organisation. They told us, "I don't do it for the company, I do it for my clients" and "Right now at the moment I do not want to be with Carby." Staff also expressed dissatisfaction with the system of fines that were in place for absence and failure to complete medicines records correctly. The fines represented a significant proportion of a care worker's wage and present risks to people's safety.
- The provider had committed significant resources to improving the service and dealing with the issues identified, including implementing monthly staff rewards to recognise good care and other inducements. They have learned from the complaints and concerns raised in recent months, including the significant concerns that had been raised with the CQC by relatives and whistleblowers.
- The management team were aware of, and had been using, several external resources to bring their practices up to date, including NICE guidance around the management of medicines, Skills for Care resources, CQC guidance and other resources. However, the learning from these was not yet fully embedded throughout the organisation.

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

- Several people and staff told us the office did not communicate well with them about day to day issues with the service, such as cancellations and staff running late, and that this was an ongoing problem. One person said, "They are like a brick wall… they say they will call back and they don't, and you're left hanging… there's been no improvement." Another person told us, "The office can be forgetful. I cancel appointments and they don't always let the carer know. It happened this morning." A care worker told us, "It's frustrating when I go to a visit and it's been cancelled, especially when I'm running behind."
- Some people and relatives were aware there had been significant changes to the management team and

office staff over the past few months. People told us, "The staff there change often, they can be very rude" and "I think they have a lot of people start, then they leave."
● The new manager was engaged in improving the service. The provider had taken immediate action when concerns were highlighted to them about the standard of care under the previous registered manager. The management team had been open with the CQC and the local authority contract compliance team about the issues that have been identified by the service, and the consequences this has had for the standard of care being provided.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The previous registered manager had left three months prior to the inspection. The provider had recruited a new manager who started work the same week as our inspection. As he was very new in post he had not yet made an application to register with the CQC as the manager.
● Staff had a clear understanding of their roles and responsibilities. New staff had been recruited with specific skills to target identified shortfalls, including around medicines management and training.
● The provider notified us of significant events and has provided further information when required.
● There were regular, unannounced spot checks of staff and these were recorded and followed up appropriately. A staff member told us, "I was making the same mistake for a while having been shown wrongly. This was picked up in December, I was retrained and everything was cleared up."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Some staff told us they felt supported by the office. Staff told us, "They made me feel very welcome, they really understood my situation" and "The flexibility is the good thing. It works around my child care and I can change my hours during the school holidays." Another said, "They are quite all right. I pop in whenever I have a concern."
● Prior to our inspection, the provider had begun visiting people to review their assessments and service plans, and carry out quality checks, prioritising people who need the most support with their medicines.

Working in partnership with others
● The service worked in partnership with other professionals when required, such as physiotherapists and occupational therapists. One staff member told us they had been guided by district nurses in aspects of someone's 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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe administration of medicines. Regulation 12(1) and (2)(g)