Greenwrite Healthcare Limited

Greenwrite Healthcare

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Greenwrite Healthcare is a domiciliary care agency registered to provide personal care to people living in their own homes. Not everyone who used the service received 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 the inspection eight people who lived in Hertfordshire were receiving personal care from the service.

People's experience of using this service and what we found
People were placed at undue risk of harm. Risk assessments for people at risk of developing pressure sores did not include all the known risks. The risk of fire was not robustly assessed as risks such as smoking, the use of emollient creams and equipment was not considered. Staff were carrying out a procedure with specialised equipment without training or relevant guidelines in place. People's medicines were not always managed safely. Staff were not taking part in the government's COVID-19 testing programme for homecare workers. We could not be assured that all staff had been recruited safely as records showed there were many more staff working who were not included in the provider's list of safely recruited staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There were systems in place to monitor the quality of the service however, they had not identified all the issues that we found during this inspection. Feedback from the people we spoke with was mostly negative about how the service was managed. We received comments such as, "There is total chaos" and "The organising of the carers is due to poor management."

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 1 July 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when. At this inspection not enough improvement had been made and the provider was still in breach of regulations. The overall rating for this service has deteriorated from requires improvement to inadequate and is the fourth consecutive inspection with a less than good rating.

Why we inspected
This inspection was prompted by monitoring activity that took place on 7 October 2021. Monitoring activities involve a structured call to the provider or manager of a service, gathering information about the experiences of people using the service and additional evidence requests when required. The provider was unable to assure us that they had made the necessary improvements during the monitoring activity, so a decision was made to inspect the service.

We undertook this focused inspection to check the provider had followed their action plan and to confirm they were meeting legal requirements. The report only covers our findings in relation to the Key Questions of Safe, Effective and Well-led. The ratings from the previous comprehensive inspection not looked at on this occasion were used in calculating the overall rating for this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Greenwrite Healthcare 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 have identified a continuing breach in relation to the safe recruitment of staff and further breaches related to safe care and treatment, consent to care and good governance.

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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? Further information is in the detailed findings below.	**Inspected but not rated**
Is the service well-led? The service was not well led. Details are in our well led findings below.	**Inadequate**

Greenwrite Healthcare

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 carried out this inspection. Calls to people receiving care were carried out by an expert by experience during the monitoring process. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Service and service type
This service is a domiciliary care service. It provides personal care to people living in their own homes.

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

Notice of inspection
We gave the provider 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure the registered manager would be in the office to support the inspection. Inspection activity started with a visit to the office on 14 October 2021 and we made follow-up visits on 15 October and 19 October 2021.

What we did before the inspection
We reviewed the information the CQC held about the service. This included notifications of significant incidents reported to the CQC and the previous inspection report. 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.

During the direct monitoring process, we spoke with two people who were receiving care and two relatives of people who were receiving care.

During the inspection
We spoke with the registered manager (provider) and the newly appointed branch manager. We reviewed a range of records, including six people's risk assessments and accompanying care plans. We looked at six staff files and various records relating to the running of the service, including quality assurance documents, accident and incident records and the minutes for staff meetings.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We contacted four health and social care professionals for their views about the service and received written feedback from one professional. We spoke with three care workers.

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 deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At our last inspection the provider had failed to operate sufficiently robust recruitment practices to ensure all staff had the appropriate competence and skills to safely perform their roles and responsibilities. This was a continued breach of regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found further issues with staffing and recruitment at this inspection and the provider continued to be in breach of regulation 19 (fit and proper persons).

- We could not be assured that all staff delivering care had been safely recruited. Prior to the inspection the registered manager told us there were six permanent staff and six regular agency staff delivering care. The recruitment files for the permanent staff showed the provider had followed safe recruitment processes for these members of staff. The provider also had profiles of the six agency staff which showed their credentials and training. However, the care logs we sampled for August and September contained 24 different initials of people who had delivered care during that period. The registered manager could not identify these people by their initials. We asked the manager to provide a list of initials used by the permanent and temporary staff but the list they provided still left 19 staff who could not be identified.
- We also compared the care log books with the staff rotas supplied by the registered manager and we found numerous occasions where the person scheduled on the rota did not match the person who had signed the care log books. We asked the registered manager to account for this and they told us that staff were using multiple different initials on different occasions. We also saw examples of care log entries with no signature, so we were also unable to identify who had delivered the care on those occasions.
- People's feedback corroborated this, and they told us they did not receive care from regular staff. We received comments such as, "I have had 22 different carers", "Staff do chop and change" and "No, I have a lot of different carers". The failure to account for all the staff means we cannot be assured that all the people delivering care and support have been suitably vetted, inducted and trained.

The failure to ensure safe recruitment practices was an ongoing breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People also told us that there were issues with timekeeping, and they did not get their care visits at the scheduled time. We received comments such as, "They don't always arrive on time" and "Time keeping, I have told them, it was ok for a week, then back to bad". Our analysis of the log books and the rotas also showed that care visits often happened much later than the scheduled time on the rota.

Assessing risk, safety monitoring and management

● People were not protected from the risk of harm and we identified several risks that required immediate action. One person's care plan indicated they needed staff to assist them to use specialised equipment as they were at risk of aspirating (breathing in) fluids into their lungs which could put them at risk of developing chest infections. There was no risk assessment in place for this health risk and no guidelines for staff to follow. Staff had not received any training to ensure they were able to carry out this procedure and their competency had not been assessed. When we asked the registered manager about the guidelines and risk assessment, they initially told us only they were not in place as only they carried out this procedure. However, daily care notes showed staff were regularly carrying out this procedure. A relative of this person told us "Not one of the care team can use the suction machine properly. We feel certain, that they put the machine on but do not attach it, so it sounds like it is working but it isn't". We raised these concerns with the registered manager, and they have now confirmed that they have instructed staff not to carry out this procedure until they have received the necessary training and their competence has been assessed.
● The risk of developing pressure sores was not adequately assessed and measures to mitigate the risk were unclear. The provider was using a recognised assessment tool to help determine people's risk of developing pressures sores. Many assessments we reviewed did not consider known risks such as previous pressure sores, incontinence and poor appetite when assessing the level of risk. For example, one person's assessment said their skin was intact and healthy and there were no risks associated with continence issues. However, communication between their relative and social services showed they had recently been suffering from a pressure sore. Their care plan also showed they had longstanding issues with continence and were using incontinence aids. These factors were not considered when assessing the level of risk.
● The risk of fire was not adequately assessed. Some people were at higher risk due to personal factors such as smoking, the use of equipment such as pressure relieving mattresses, poor mobility and the use of emollient creams. One person's care plan showed they were a smoker, with reduced mobility and were using a flammable emollient cream. However, these risk factors had not been considered and the care plan stated, 'The care provider undertook a fire risk assessment and appears no risks have been recorded.' The failure to identify these additional risk factors meant there was an increased risk that the person could be harmed by a fire within their home. We raised these concerns with the registered manager, and they have now put in place individual fire risk assessments which contain all risk factors. However, these still lacked sufficient guidance on how to mitigate the risks and we have asked the provider to re-review these.
● There was a lack of evidence that moving and handling equipment being used by staff was safe and was being regularly maintained. Care plans did not contain information on the model or maintenance history of moving and handling equipment or any details of who was responsible for maintaining these. When asked the registered manager told us it is the responsibility of the local authority, but they did not have any record of ongoing maintenance checks. This meant they could not be assured that equipment being used by their staff was safe to use.

The failure to have an effective system in place to identify and mitigate risks, and ensure staff had the necessary training to provide safe care was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not managed safely. We identified issues with both medicine administration records (MARs) we reviewed. One person's MAR which had been signed by staff was missing the names, dosage and instructions of the medication so it was impossible to know what medication the staff had administered. This MAR chart also contained numerous gaps which had not been investigated. These issues had not been identified in the manager's medication audit. Another person's MAR did not contain any personal information such as name, date of birth and allergy information. This person was also prescribed a barrier cream for people with damaged skin or those at risk of damage. The care plan, medication assessment and

MAR stated this was to be used 'as required' but there was no information on any of these documents to indicate where this cream should be applied. The care plan and medication assessment also stated it was 'suitable for use as a substitute for soap in the bath or shower or when cleaning the skin' which is not the recommended use of this product.

The failure to manage people's medicines safely was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Staff had received infection prevention and control (IPC) training to give them an understanding of how to protect people from the risk of infection. Training included ongoing guidance and updates regarding COVID-19. Staff told us the registered manager often spoke with them about their IPC responsibilities, which was a standing discussion topic at the staff monthly meetings. However, people, their relatives and representatives provided mixed views about how staff adhered to safe infection and prevention practices. One person told us, "They run out of masks and on a regular basis."

● Staff were not carrying out weekly COVID-19 tests according to current government guidelines. The updated government guidance which was published 1 July 2021 states 'every 7 days a care worker should take a test, register it online, and return it by post between Thursday and Sunday'. The staff minutes referred to LFD (later flow) tests only which are not part of the regular testing programme for homecare workers and there was no evidence that staff had conducted any regular COVID-19 tests.

The failure to manage infection control and adhere to current guidance was a 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

● People received their care and support from staff who had received safeguarding training to protect them from abuse, neglect and harm. Staff told us they would inform their line manager if they had any concerns about a person's safety and/or welfare. The provider informed the local authority when they were concerned that one person was at risk of financial abuse. However, not all staff understood what the term 'whistleblowing' meant which is a basic concept about raising concerns about wrongdoing that all social care workers are expected to know and understand.

Learning lessons when things go wrong

● At the last inspection we found the provider had improved the process for recording accidents, incidents and safeguarding concerns. At this inspection we found this improvement had been sustained and there were records in place. Team meetings' minutes contained information about recent safety incidents.

Inspected but not rated

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 Requires Improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about. We will assess all of the key question at the next comprehensive inspection of the service.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● The service was not adhering to MCA guidelines. Mental capacity assessments were not always carried out when the provider had cause to suspect people did not have capacity to consent to their care. When mental capacity assessments were completed, they contained conflicting information.
● One person's care plan stated a family member had power of attorney for finances and welfare, but the provider had not seen evidence of this. When we discussed this with the registered manager, they told us that this was the information contained in the social worker assessment. However, the social worker assessment we reviewed did not contain this information so the provider could not show they had taken reasonable steps to assure themselves that this person's family member had the legal authority to act on their behalf.
● Another person's mental capacity assessment contained conflicting and misleading statements about their capacity to consent to their care. One part of the assessment stated they were unable to understand, retain, use and weigh the information in order to make the decision about their care and support. However, later in the same document the outcome of the assessment was they did have capacity to make this decision. We discussed this with the registered manager, and they did not understand why these conflicting statements were problematic. This indicates a lack of understanding on the principles of the Mental Capacity Act.

The failure to ensure the principles of the MCA were followed was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 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;

At our last inspection the provider had made some improvements in how they assessed, improved, monitored and sustained the quality of experience for people who used the service. However, further improvements were still needed. At this inspection we found that improvements had not been sustained and we found multiple issues with the management of service delivery.

- This inspection was prompted in part by the provider's failure to give the necessary assurance of good governance during the direct monitoring process. During that process the provider did not send us the requested documents in the agreed time period. During the inspection the registered manager was also not able to immediately access all the information we needed due to issues with their internet and accessing their own IT system. They told us the internet connection was a recurrent issue.
- Many assessments were not signed or dated or did not contain a review date. When reviews of care were carried out, care plans were not always updated with current information. For example, one person had moved address, but their care plan had not been updated with the new details.
- The authority had investigated and substantiated an allegation that one person was left without care during August and September. There was evidence that this person was regularly declining care and refusing care staff access to their home. However, this behaviour was not recorded in their care plan and there was no agreed plan in place for when the person did not answer the door to the care staff.

Continuous learning and improving care

- Quality audits supplied during the inspection did not identify all the issues we found with medicines, risk management, record keeping and adherence to the Mental Capacity Act 2005. Despite previous improvements in staff recruitment at this inspection the provider could not account for all the people who were delivering care.
- Fire risk assessments produced after we shared our concerns were backdated, in some cases to more than 12 months before they were written. Skin integrity assessments produced after we shared our concerns still did not consider issues such as incontinence. One person's reviewed skin integrity assessment stated 'We are unable to grade the [continence] because the service user has capacity to make decision when to be incontinent and when to use commode or use the toilet."
- The registered manager told us they had been working with a consultant to help make improvements and develop their improvement plan. We asked for a copy of the provider's improvement plan on several occasions but still have not received this.

● The registered manager had recently recruited an office manager who would assist the registered manager with systems and processes in order to drive improvements. As this person had only been post for a few days we were not able to assess their effectiveness.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● Care logs we reviewed did not always show evidence of person-centred care. Some care logs contained undignified language when referring to incontinence aids. We also saw examples of staff using the same care log for different family members who were both receiving care from this provider.
● Issues with record-keeping were observed by people receiving care. One person told us, "They run out of writing paper. I have also found out that they were writing false times in the book."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● There was evidence that the provider was regularly reviewing people's care and asking for feedback through telephone monitoring. The feedback obtained during telephone monitoring was largely positive. However, this did not align with the mostly negative feedback we received when we made calls to people and their relatives. Some people told us they were contacted on a "regular basis." However, other people told us the provider "did not often" contact them to see how things were going. Another person told us, "No, I am not listened to, sometimes not at all." People also told us they also felt staff were not equipped to carry out their role. One person told us, "They don't appear to have any training."
● We saw evidence of monthly staff meetings. However, the minutes of some meetings were an exact duplication from the previous month and so could not be an accurate record of what was discussed.

The failure to assess, monitor and improve the quality and safety of the service effectively was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 understood their responsibility to be open and honest and give people all the relevant information when things went wrong. They sent the appropriate notifications to CQC after significant events occurred.

Working in partnership with others
● The service showed joint working with other organisations and local professionals. The registered manager attended multi-agency meetings and contacted health and social care professionals such as district nurses and occupational therapists when required.