Williams CM Ltd

# Williams CM Ltd

## 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
Caremark (Walsall and Wolverhampton) is a domiciliary care service that was providing personal care to 51 people on the first day of our inspection. The service supports adults with dementia, learning disabilities or autistic spectrum disorder, physical disability and sensory impairments.

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.

When we inspected the service, we found they were not providing the service from the location registered with CQC, we have discussed this within the report.

People's experience of using this service and what we found

Systems or processes were not operated effectively as the provider had failed to ensure there was consistent and effective leadership of the service. This meant the provider had little oversight of the service which placed people at risk of harm through not receiving consistent safe care.

People were not safeguarded from potential abuse and neglect as there had been occasions where adult abuse was not recognised and reported to local safeguarding teams.

People's risk assessments were not always accurate and up to date with information about their needs. This placed people at risk of not receiving care in line with their needs as staff did not always have guidance in place to meet these.

People's medicines records contained gaps that could not be explained and there was no oversight or audits of systems to manage people's medicines. This meant there was limited assurance that people had their medicines as prescribed.

People were not protected from the risk of COVID-19 as the provider had no systems in place to monitor and mitigate risks relating to COVID-19. The provider had also failed to ensure staff had training in relation to COVID-19. People did tell us staff used facemasks, gloves and aprons when providing care.

People were not supported by staff who had been recruited safely as not all staff were subject to the full range of checks needed to ensure they were safe to work with vulnerable people before they commenced worked.

People were unhappy with the number of staff that visited them as opposed to a consistent group of staff. Despite this people did say they got on well with the staff visiting them.

People had raised complaints through the provider's telephone monitoring calls, and these had not been investigated by the provider. This meant people were not be reassured their views would be considered and used to improve 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

The last rating for the service at their previous location was Good (published 27 February 2019).

Why we inspected

We received concerns in relation to staffing, people's safety, management of medicines and management. 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. We have not reviewed the rating for effective, caring and responsive. This is because we only looked at the key questions we had specific concerns about. 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 Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Caremark (Walsall and Wolverhampton) 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 breaches in relation to safe care and treatment, staffing, fit and proper persons employed and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

The overall rating for this service is '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.

# Williams CM Ltd

**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

This inspection was completed by one inspector.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service did not have a manager registered with the Care Quality Commission. This meant the provider was 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 19/01/2021 and ended on 09/02/2021. We visited the office location from where the regulated activity personal care was carried on from (which was not the registered location) on 19/01/2021, 02/02/2021 and 09/02/21.

What we did before the inspection

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 carried out an assessment of the location through our transitional monitoring approach prior to our decision to inspect the service. This is where we review all the information that we have about the service and subsequently have a conversation with the registered person either online or by telephone. This is not an inspection and we do not rate services following this approach. Concerns identified during this review meant we decided to complete a focussed inspection.

We used all of this information to plan our inspection.

During the inspection

We spoke with four people who used the service and five relatives about their experience of the care provided. We spoke with twelve members of staff including the provider, acting manager , care coordinators, field care supervisors and care workers. We spoke with a National Operations manager from the Caremark Franchise during the inspection. We also spoke with commissioners from the relevant local authorities who commissioned care packages provided by the provider and one social worker.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection

We continued to seek clarification from the acting manager and provider to validate evidence found.

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 good. At this inspection this key question has now deteriorated to inadequate.

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

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong

- People were not always safeguarded from abuse and neglect. For example, one person alleged a staff member had hurt them whilst providing personal care. A staff member who witnessed the abuse agreed with this allegation and stated they had caused the person to bruise. This was not reported to a senior member of staff until the day after the incident or reported to the Local Authority safeguarding team. The provider had not raised any safeguarding alerts prior to our inspection. This meant people had been placed at risk of prolonged harm and neglect.
- People were not always supported by staff who understood safeguarding. For example, despite recent safeguarding training, some staff were not aware of what statutory bodies were responsible for dealing with allegations of abuse.
- One staff member told us, "I would report [concerns] to the office. Never come across [this] to date but not aware of what to do if the office did not follow up".
- The provider was not able to evidence that there was a robust system in place to promote learning when areas requiring improvement were identified.

This placed people at risk of harm. 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.

- Despite this, people we spoke with said they felt safe. One person said, "I'm quite safe and quite happy".

Assessing risk, safety monitoring and management

- People's care records did not always contain accurate and up to date information about their needs. For example, a person reported to staff when they attended a call they had fell from their bed. Staff did not complete an accident form and the person's risk assessment had not been updated. This placed people at risk of not receiving care in line with their needs as staff did not always have clear guidance in place to follow.
- The provider had failed to ensure staff had sufficient training to meet people's needs. For example, one person required staff to administer their medicine and food through a Percutaneous endoscopic gastrostomy tube (PEG). A PEG is a flexible feeding tube placed through the abdominal wall and into the stomach to allow nutrition, fluids and/or medications to be put directly into the stomach. However, staff did not have current training in PEG care and therefore a relative was having to provide this care.

Using medicines safely

●People's medicines administration records (MAR) were not always completed correctly by staff and contained gaps in recording. This meant it was not clear if people received their prescribed medicines.

●The acting manager was unable to show us any audits of people's MAR that should have identified these gaps so they could be investigated, and action taken to correct this. This indicated there was ongoing risk to people not receiving their prescribed medicines.

● Prior to the inspection we were contacted by a staff member who raised concerns a person had been given two lots of medicines by staff. The staff member said they had escalated this to a senior member of staff but was still concerned due to the person's specific health conditions. This concern had not been raised the Local Authority safeguarding team. We discussed this with the acting manager who was unclear as to what action was taken as it was dealt with by a previous acting manager.

●People we spoke with did not raise any concerns in respect of how their medicines were managed. One person told us, "Staff do help with eyedrops and there are no issues".

Preventing and controlling infection

●The provider failed to ensure Government guidance in relation to COVID-19 was followed. For example, during our inspection staff were not wearing face masks. In addition, the provider had no policies and procedures in place in relation to management of risk of COVID-19. For example, there was no procedures on staff testing, car sharing or risk assessment where staff had underlying health conditions present. This placed people and staff at risk of increased transmission of infections such as COVID-19 and the harm associated with these.

●People were not supported by consistent staff. One person told us, "I do have different carers". This placed people at risk of increased risk of transmission of COVID-19.

●The provider had failed to ensure staff were having weekly testing for COVID -19 in accordance with government guidance. One member of staff said, "No weekly staff COVID-19 tests and there was one occasion where I had contact with someone with COVID -19. I was asked to go into work as they said I would only be asymptomatic, fortunately the test showed was negative". The nominated individual confirmed they had received staff test kits after our inspection. This placed people and staff at risk of harm.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People said staff used personal protective equipment (PPE) when providing care, this including face masks, gloves and where needed aprons. A relative told us, "Staff wear aprons masks and gloves, everything".

Staffing and recruitment

● The provider had failed to ensure they had sufficient staff to meet people's care needs. For example, external professionals informed us the provider had handed packages of care back to them due to not being able to cover calls. This has been a very short notice on occasions which had compromised the safe delivery of people's care.

●People were not supported by consistent care staff who knew them well. One person told us, "I get different carers, I don't really know whom I am getting. I do like to have the same carers". A relative told us, "Calls not always very steady, some days four different carers". This placed people at risk of receiving inconsistent care.

● Staff were not recruited safely. For example, there were gaps in staff pre-employment checks. Some staff records did not have a full record of their working history and there was no explanation of the gaps within these. In addition not all staff members were subject to health checks to ensure they were fit to complete

their roles.

●There was one occasion where a member of staff was not subject to a Disclosure and Barring check (DBS) before commencing work with people. In addition, there was no risk assessment in place to state what steps the provider had taken to protect people due to no DBS being obtained. This was discussed with the provider and they have sent evidence of staff employed recently without a DBS are subject to all expected recruitment checks and a risk assessment whilst awaiting their DBS.

This placed people at risk of harm. This was a breach of regulation 18 (Staffing) and regulation 19 (Fit and proper persons employed) 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 good. 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.

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

- The provider had failed to ensure quality monitoring systems were in place to ensure people received safe care in line with their needs. At this inspection we found multiple breaches in regulation. For example, the provider had poor oversight of the service, allegations of abuse went unreported, there was no auditing of medicines administration, there was no oversight and gaps in staff training/supervision and inconsistent record keeping related to management and service user records.
- Staff we spoke with confirmed there was a lack of effective support and oversight at the service. One staff member told us, "[The] last two months there has been overloaded workload", and, "Never had a spot check, not sure if it's because I do evening calls, even told them and still no checks. No supervision". This placed people at risk of unsafe and inconsistent care.
- We received mixed feedback from people and their relatives, and no one knew the nominated individual for the service. One person told us, "I get different carers but don't really know whom I am getting, I do like to have the same carers. Carers are alright and can get on with them". A relative told us, "I have noticed things have changed under the new provider. Care staff themselves are lovely but there are issues and its very important regarding the continuity of care – I think the staff in office, their hands are tied".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

- The service has not had a registered manager in post since April 2020. This was a breach of the provider's conditions of registration. The acting manager left the service during our inspection as they did not feel supported by the provider. Following our inspection, the provider told us they had appointed a new acting manager.
- The provider had notified CQC of a change of address when they moved office in October 2020 but despite prompts did not vary their registration as legally required. The provider told us they have returned to their previous registered location since our inspection following our discussion with them in respect of this breach of conditions.
- The provider had failed to act in response to known concerns. For example, the Caremark Franchise had completed a review of the service in December 2020 identifying actions that needed immediate attention. Actions needed included, documentation related to people's records not in place, no medicine audits, lack of documentation to show follow up from safeguarding issues, lack of care staff, /staff overworked and gaps

in staff records. These findings reflected those identified during our inspection. This placed people at risk of prolonged poor quality care.

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

● Following an allegation of abuse from a person, not raised as a safeguarding alert with the relevant safeguarding agency, a telephone review was completed by senior staff with a relative of the person. Despite the recent allegation the provider had received there was no record to show the allegations had been shared with the relative, and no record of any explanation or if appropriate apology for this incident. This meant the provider had not acted on their duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had failed to ensure people and their relatives concerns were acted on in a timely way. For example, senior staff had completed telephone reviews with people but where concerns were raised there had been not follow up to address these and feedback findings.

● The provider had failed to send out recent quality questionnaires to gain feedback from people, stakeholders and staff.

Working in partnership with others

● We had received numerous concerns from commissioners that the provider was not working in partnership with them. For example, numerous requests for information following receipt of concerns were delayed or not responded to. This included the service's lack of ability to cover packages of care contracted to them and handing these back to commissioners at short notice.

This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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<br><br>The provider was not providing safe care and treatment for people as they had failed to ensure people's care records contained comprehensive, accurate and up to date information about their needs. In addition, there were no systems in place to provide assurances that people had received their prescribed medication when records did not evidence this. This placed people at risk of harm as it was not always evident what steps were to be taken to avoid harm to people. In addition, systems to protect people from infection from COVID-19 were not robust and reflective of Government guidance. |

**The enforcement action we took:**

We issued a Notice of Proposal to cancel the regulated activity Personal Care

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Allegations of abuse had not been appropriately handled by the provider and showed people were at risk of abuse as allegations were not report or handled appropriately and learning recognised. |

**The enforcement action we took:**

We issued a Notice of Proposal to cancel the regulated activity Personal Care

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems or processes were not operated effectively to ensure compliance with the requirements of the regulations as the provider had failed to ensure there was consistent and |

effective leadership in place at the service and systems and processes had not ensured effective oversight of the service and compliance with the regulations. This placed people at risk of harm through not receiving consistent good quality care.

**The enforcement action we took:**

We issued a Notice of Proposal to cancel the regulated activity Personal Care

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider was not operating effective recruitment processes to ensure persons employed were of good character and were fit for the purpose for which they were employed. |

**The enforcement action we took:**

We issued a Notice of Proposal to cancel the regulated activity Personal Care

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were insufficient numbers of staff members to meet the requirements of the regulations. Additionally, staff members had not received appropriate support, training, supervision and appraisal to ensure they were able to provide safe care to people. There was a lack of robust systems in place to ensure staffing was managed in a consistent way. The provider had failed to ensure staff<br>members had sufficient training and support to consistently enable staff members to<br>support people in a consistently safe way. |

**The enforcement action we took:**

We issued a Notice of Proposal to cancel the regulated activity Personal Care