Community Care Worker Limited

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Inspection report

Wood House
Etruria Road
Stoke-on-trent
ST1 5NQ

Tel: 01782817920
Website: www.communitycareworker.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Community Care Worker Limited is a domiciliary care service that provides personal care to people living in their own homes. At the time of our inspection the service was providing personal care support to approximately 180 people. This number could only be approximated as the provider was unclear about how many people they supported with personal care.

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 were not always kept safe as safeguarding concerns were not always acted upon or reported to the local safeguarding authority. There were not enough staff available to cover all calls so some people experienced missed calls. People had been left at risk as a result of some missed calls. Medicines were not always managed safely. The provider had not followed government guidance about the COVID-19 testing for staff.

There was ineffective oversight of the quality and safety of people's care and support. Quality assurance systems were not effective at identifying concerns and acting upon these. The provider had poor oversight of staff roles and responsibilities. People, relatives and staff had concerns about poor communication with the office. The provider had not always worked in partnership with other organisations. Notifications were not always submitted as necessary.

Staff did not always have enough training to feel confident in their role. One staff member was sent out to administer medicine without training which put people at risk. People did not always have access to other health professionals when needed.

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. However, some people's capacity assessments could be more robust.

Staff were following guidance about personal protective equipment and wearing these whilst in calls. People were supported to access food and fluids when this was needed as part of their care. The previous inspection rating was being displayed as necessary.

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 9 April 2021).

Why we inspected
The inspection was prompted in part due to concerns received about medicines, alleged poor moving and handling, missed visits and lack of consistency of staff. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. During the inspection we decided to look at effective also.

We have found evidence that the provider needs to make improvements. Please see the safe, effective 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.

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 inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified breaches in relation to the oversight of the quality and safety of care to people, safeguarding people, staffing levels and the training for staff, safe care and treatment and the management of medicines 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
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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 of 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? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Community Care Worker Limited

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 site visit was carried out by three inspectors and an inspection manager. Inspectors made phone calls to people, relatives and staff. An assistant inspector assisted with phone calls to staff. An Expert by Experience also made phone calls to people and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Community Care Worker Limited is a domiciliary care service, providing personal care in people's homes.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 14 July 2021 and ended on 9 August 2021. We visited the office location on 14 July 2021, 27 July 2021 and 9 August 2021.

What we did
We looked at information we held about the service including notifications they had made to us about

important events. A notification is information about events that by law the registered persons should tell us about. 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 also asked Healthwatch if they had any information to share. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not have any feedback to share. We also asked the local authority, who the provider had a contract with, for feedback. They told us they had concerns about some of the quality of care. We used all of this information to plan our inspection.

We spoke with eight people who used the service and 18 relatives over the telephone. We also spoke with a range of health and social care professionals for feedback. We spoke with 17 staff members either during our visits to the office or over the telephone. This included carers, senior carers, care co-ordinators and the trainer. Whilst visiting the office we also spoke with the registered manager and the nominated individual from the provider. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke to one of the consultants the provider had employed to support the service.

We reviewed 22 people's care records including some medicine records and electronic records. We also looked at records relating to the management of the service, including audits, meeting minutes, surveys and seven staff recruitment files.

After the inspection
The provider sent us further documentation about their oversight of the service, including electronic call monitoring records, training records, meeting minutes and electronic care plans.

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 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 protected from the risk of abuse and lessons were not always learned when things had gone wrong.
- All staff were aware of the different types of abuse and their responsibility to report concerns. However, staff gave us examples of concerns they had reported to the office. We found examples of concerns they had recorded on their system, but the registered manager had not taken action to investigate, protect people and had not always reported to the local safeguarding authority.
- We also found examples of concerns in people's care records which had not been identified and reported or dealt with.
- For example, one person had bruises and a possible bite mark which had not been checked on, there were some missed calls identified which had put people at risk and staff had reported concerns about family members allegedly abusing people.
- As action had not always been taken in response to concerns, we could not be sure lessons were always learned when things had gone wrong.
- We had to make multiple safeguarding referrals as a result of our inspection as we had concerns about people at risk of harm or who allegedly had come to harm.

The above evidence constituted 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.

Staffing and recruitment;

- There were not enough staff to safely cover every person's planned calls, particularly those who needed two staff to attend each call (known as double-up calls).
- One person said, "No, there's definitely not enough [staff]. I thought they were never coming. It makes me feel fed up." A relative told us, "They've [the provider] even sent one carer when there should be two and asked me to oblige and help out. They ask quite often."
- Multiple people experienced missed visits, either where no staff attended a call or, more commonly, only one staff member attended but they needed two staff. This put people at risk of receiving unsafe care.
- Due to the provider having to arrange for different staff to cover calls, some people did not have consistency and saw multiple different staff each week who they did not know. In one example, one person who had double-up calls was visited by 50 different staff in a one-month period. Another person said, "You never know who is going to come through the door."
- The provider had experienced a high turnover of staff which they felt coincided with the lifting of government COVID-19 restrictions so staff returned to previous employment resulting in staff shortages.

● There were checks carried out on staff suitability to work with people who use the service. Checks included criminal records and references from previous employers. However, there were unexplained gaps in staff employment history records. It is a requirement to have a satisfactory written explanation for any gaps.

The above evidence constituted a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management;
● People had been put at risk due to the safe amount of staff not always being supplied in line with people's assessed needs.
● People and relatives had mixed feedback about the care they received; some felt it was positive whereas others did not have a good experience. One person said, "I am looked after very well by the staff. They have become my friends. I look forward to seeing them." However, one relative said, "This is the worst care company I've had. I've been in tears more than once about this."
● Some people needed support with moving and handling equipment to reposition themselves or to get in and out of bed. Lots of this equipment needed two staff to be able to support people safely. However, as there had been occasions only one staff member had attended calls, people had been left at risk as they had sometimes been supported by only one staff member, or they had not been able to receive the support they needed.

People had been exposed to the risk of harm due to the assessed amount of care not always being supplied. This constituted 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 always managed safely.
● Some people were having topical creams applied by staff which was not included on their medication administration record (MAR). This meant we could not be sure staff were applying prescribed topical medicines, and whether staff were following the instructions correctly. This could leave people at risk if staff were applying creams or gels that had not been prescribed or checked they were safe to apply.
● Following the inspection, the consultant sent us copies of some medicine errors the provider or registered manager had investigated whereby ambulances were contacted. The record of the investigation was poor, with lack of detail about what had gone wrong and what had been investigated. Therefore, we could not be sure appropriate action had been taken in response to these medicine errors and people could have been left at risk.
● We also found one example of a staff member recording they had given a double dose of a medicine as they had to combine two calls into one as they had been running so late. The person did not come to harm as a result of this however people should not be given extra medicine due to calls being combined.

People had been exposed to the risk of harm as medicines were not always managed. This constituted 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
● People were protected from the risk of cross infection, however government guidance about staff testing for COVID-19 was not being followed by the provider.
● During the COVID-19 pandemic, extra guidance was in place for staff to follow to help keep people safe

which included a weekly polymerase chain reaction (PCR) test (a test which gets posted back to a laboratory and a result sent back to the staff member). However, staff had not been carrying these out and had just been completing lateral flow test (LFTs) whereby the result takes half an hour to show on the test strip.

● The provider was also not robustly monitoring that staff were carrying out tests. Therefore, people could have been left at risk of contracting COVID-19 as the provider had not ensured staff had carried out the appropriate regular COVID-19 tests.

People had been exposed to the risk of harm due to government guidance about COVID-19 testing not always been followed. This constituted a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and staff confirmed staff wore appropriate personal protective equipment (PPE), such as a mask, gloves and aprons, when necessary during visits. One person said, "They [staff] always wear a mask and wear gloves and aprons."

Requires Improvement

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 good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not always receive sufficient training to be effective and feel confident in their role. Staff also gave us mixed feedback about the training, some feeling it was enough, others not.
- People and relatives also gave us mixed feedback about staff training. One person said, "I don't think the staff are trained enough. Once they sent a staff member out of the office to see me as they had no one else. I don't agree with that." A relative said, "I don't think they [staff] are trained at all, not the way they care for my relative." Another relative said, "The carers appear to be new starters with very little experience, but not getting the training they should be getting." Whereas one relative said, "The staff always appear to be able to use the equipment when necessary. I think they are well trained."
- Staff comments included, "If I had not worked in care previously, the induction would not be enough"
- One staff member was sent out and expected to administer medicines to two different people, however they had not been trained to carry out this task. This put people at risk of unsafe care as they may not have received their medicines safely. This had resulted in safeguarding concerns being raised.

The above evidence constituted a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People were not always supported to access assistance from other health professionals when needed. Relatives gave us examples where staff had not always contacted health professionals, such as an ambulance or a district nurse. This meant people had been exposed to risk to their health and well-being.
- Also, as mentioned in the safe key question, the provider had failed to ensure staff were carrying out COVID-19 PCRs tests in line with government guidance, therefore we could not always be sure guidance would be followed.
- People had risk assessments and care plans in place which detailed their health and support needs. The provider also received initial care plans from the local authority when the local authority asked them to deliver care to people. However, as some people were not always receiving the care the local authority had planned for, we could not be sure these were always followed.
- When people had specific needs in relation to their religion or beliefs, this was included in their plan to assist staff to know how to support them appropriately.

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.

● People's mental capacity was being assessed and recorded. Overall, this was being done clearly, however there were some people who had relatives recorded as either giving consent or as being involved in the person's care and treatment care plan, without the relevant legal authority being evidenced. However, people were still involved where possible in their care. Despite this, other people's care records had their ability to consent appropriately documented.
● One person told us, "I was very involved in my care plan."
● Staff understood people had the right to make their own decisions and staff had to assume everyone had capacity. One staff member said, "I always assume capacity and offer choices unless there are stated limitations or best interest decisions in place, but even then, you can't force someone to do something."

Supporting people to eat and drink enough to maintain a balanced diet
● Many people were supported by their relatives in relation to food and drinks. One person said, "My meals are always made for me, and I am always offered plenty to drink." Where necessary, there was guidance in place relating to people's dietary needs and the level of support required by staff.

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 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.

Continuous learning and improving care; Working in partnership with others

- Quality assurance systems were not effective at identifying concerns or areas for improvement therefore the provider could not demonstrate they were continuously learning and improving care.
- The provider and registered manager did not have clear oversight of who had been carrying out audits on people's daily records. These audits had not been effective as they had failed to identify concerns such as missed calls and double-up calls being done as single calls, for example.
- There was poor oversight of care delivery as missed calls had not always been identified or prevented. Following our feedback, the provider told us how they would improve this by monitoring their electronic system more closely. However, following this there continued to be further missed calls so the action they had taken had not been effective.
- We found references to medicines being given in the care notes but did not have a corresponding MAR, so there was a lack of instructions for staff and it had not been confirmed if this was prescribed and safe to apply. This had not been identified by the provider.
- Staff had documented concerns about missed calls for multiple people and unexplained bruising and marks for one person and these had not been identified despite the records being audited. The registered manager had failed to report concerns to the local safeguarding authority and therefore, systems were not effective at monitoring and improving people's care.
- Care plans were detailed, so staff had guidance about how people liked to be supported. However, some plans referred to other people's names and needs so we could not be sure they were always personalised. This had not been identified by the provider.
- The provider had not worked in partnership with the local authority they contract with when they had failed to inform them, they were unable to cover some of their calls, leading to some double up calls being done by only one staff member.
- The local authority the provider contracts with had shared numerous concerns with the provider, that people using the service had shared with them. The provider had failed to respond to many of the issues being raised. Since the inspection, the provider had worked in partnership with the local authority to address concerns, such as the covering of calls and safeguarding concerns.

There was poor oversight of the quality and safety of care. The above evidence constituted a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had already got support from an external consultant in order to assist them to learn and

improve further, although we had found multiple concerns at this inspection. We were given reassurance this support would increase and continue in order to make the necessary improvements.

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

● People, relatives and staff were not always fully engaged and involved in the service as they found communication with the office frustrating. One person said "When I ring up when no one has been to me they check, but they don't seem to know what they are on about. I don't mind ringing the office but its whether I get any joy."

● A relative told us, "The communication is a nightmare I'm sorry to say. If I phone and ask them for something, they say they'll call you back and they never call back. I just feel when I speak to them, I honestly feel they don't care. They say, 'sorry about that' but nothing ever happens so it is frustrating." Another relative commented, "I have put my piece across and believed them, but it doesn't change."

● A health and social care professional we spoke with also said in relation to calling the office, "I feel that they [staff answering the phone] are giving me the run around."

● Comments from staff included, "I call the office and share my concerns and they are not interested; they don't want to know" and, "Whoever answers the phone, it's never the same person twice. I have spoken to one of the higher managers. Nothing has really changed."

● Due to the size of the service, the office was busy with staff. Following our feedback, the provider acted on this and established an options menu on the phone system so calls would be directed to the most appropriate staff, rather than going through to anyone.

● Despite the provider having undertaken telephone surveys with people and their relatives, they had failed to find the serious concerns we gathered. This meant the surveys were not effective.

There was poor oversight of the quality and safety of care. The above evidence constituted a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● There were unclear roles and responsibilities. As mentioned above, the provider and registered manager did not have clear oversight of who had been carrying out audits on people's daily records. Multiple different job roles worked in the office and all were involved in answering the office phone, which lead to some poor communication. The provider had failed to identify that people, relatives and staff were experiencing poor quality, unsafe car and communication systems in place were not effective.

● The provider was unclear about who they were supporting with a regulated activity; i.e. personal care. This meant there was a risk people's support may not be prioritised appropriately if the provider was unclear the level of support people were receiving.

● Checks on staff members employment history had not been robust. There were multiple unexplained gaps, however it is a requirement to have written explanations for gaps in employment. Therefore, the provider had failed to do this.

● There were occasions family members would work together on a double-up rota. There was no additional monitoring of this to ensure people remained safe. Whilst we did not find evidence of people coming to harm as a result of family members working together the provider had failed to risk assess this.

● The registered manager told us they were aware of their responsibilities relating to duty of candour. However, as multiple people and relatives told us they did not always receive a call back after they have reported concerns, we could not always be sure concerns were acted upon. A relative commented, "They [a

manager or someone from the office] still haven't called me back [after an alleged concern was reported]. They never call back to apologise."

There was poor oversight of the quality and safety of care. The above evidence constituted a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback regarding missed calls, the provider and registered manager were proactive and told us they would write to those people who had been affected by missed calls in order to apologise and explain to them what measures they would be taking to prevent it from happening again.

● Notifications were not always submitted as required. A notification is information about events that by law the registered persons should tell us about. The registered manager shared some safeguarding allegations they had investigated but we had not been notified of these. In addition, there were numerous concerns we identified that should have been reported to local authority safeguarding teams and notified to CQC.

The above evidence constituted a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

● The previous inspection rating was being correctly displayed on their website and in their office as required.