Care Quality Commission

RLS Care Services Ltd

# Sycamore House

## Inspection report

Appleby Glade Industrial Estate
Ryder Close
Swadlincote
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Tel: 01283792360

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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
Sycamore House is a domiciliary care agency providing personal care for older people and younger adults in their own homes. This included people living with a physical disability, dementia and/or other long-term health conditions. At the time of our inspection 25 people were receiving the regulated activity of Personal Care.

People's experience of using this service and what we found
Continued shortfalls were identified in the systems and processes that assessed, monitored, and mitigated risks and quality. There was a lack of effective oversight and leadership of the service.

Incident and risk management, including analysis and learning lessons when thing went wrong were not fully effective. People were not sufficiently protected from the risk of abuse.

The provider had failed to notify the Care Quality Commission of all reportable incidents they are legally required to do.

Since the last inspection, there had been a significant number of missed and late calls affecting a high number of people. People assessed as requiring two care staff to support them had received calls from one care staff.

The provider had received a high number of complaints from people, relatives, external professionals, and staff raising concerns about the quality and safety of the care provided.

Staffing issues meant people's individual care and support needs were not met safety. A high number of staff had left the service since the last inspection impacting on the safe delivery of care.

Best practice guidance in the management of medicines was not followed. New staff did not receive probationary meetings to monitor their performance. Staff did not feel supported or valued and raised concerns about the quality of training, communication and organisation.

People's care plans and risk assessments were not consistently detailed with guidance for staff, of how to meet people's care needs and mitigate risks.

Infection prevention and control best practice guidance was followed.

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 Requires Improvement (published 17 April 2021). The service has

deteriorated to Inadequate.

Why we inspected
We received ongoing concerns about the safe care and treatment of people. This included concerns about missed and late calls and people not being protected from abuse. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No new concerns 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.

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 read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sycamore House 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 two continued breaches of regulation in relation to governance systems and procedures, oversight and leadership, and the provider had not informed the Care Quality Commission of all reportable incidents.

Three new breaches in regulation were identified, people had received unsafe care and treatment and had not been fully protected from abuse and avoidable harm. Staff deployment was not sufficient to meet people's needs, staff had not had probationary meetings or were supervised effectively.

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.

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 the service.

If the provider has not made enough improvement 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?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-led findings below. | **Inadequate** |

Care Quality Commission

# Sycamore House

**Detailed findings**

## Background to this 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
The inspection was carried out by one inspector, an assistant inspector, and an Expert by Experience. 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
This service is a domiciliary care agency. It provides personal care to people living in their own 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 announced. We gave notice of the inspection to give time for the registered manager to obtain peoples and relatives' consent for us to contact them, and to make sure the registered manager would be in the office to support the inspection visit.

Inspection activity started on 27 July 2021 and ended on 2 August 2021. We carried out telephone calls on 27 July 2021 to people and relatives to gain their experience of the service they received. We made calls to care staff on 27 and 28 July 2021. We visited the office location on 2 August 2021.

What we did before the inspection
We reviewed all the information we held about the service since the last inspection. We sought feedback from local authority care commissioners and professionals who work with the service. 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 five people who used the service, one relative and six care staff by telephone prior to the office visit. At the office visit we spoke with the registered manager, the provider and new nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We looked at seven people's care records, reviewed four staff files and reviewed a range of management records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed a range of key service documents, which we had asked the registered manager to send us. This included information such as policies and procedures, meeting records, staff training, the provider's action plan and additional care plans, risk assessments and care call logs. We received further feedback from two care staff.

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 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
● The provider's safeguarding systems and processes were not sufficiently robust to protect people from abuse and avoidable harm.
● The local authority responsible for investigating safeguarding allegations and concerns told us they had received a significant number of safeguarding referrals since our last inspection. At the time of our inspection safeguarding allegations were still being investigated. We will continue to monitor these. Examples of substantiated safeguarding investigation outcomes related to missed calls and neglect of care, impacting on people's safety, health and wellbeing.
● The registered manager and provider failed to follow the local multi-agency safeguarding policy and procedures. This included not reporting allegations to external organisations as required. The provider and registered manager also failed to take robust action when allegations were made about staff practice. Action to suspend staff pending an investigation was not completed in a timely manner. This is important action to protect people and the staff member from further allegations.

The provider's failure to ensure they had an implemented robust procedures and processes to make sure people were protected from abuse was a breach of regulation 13 (1) (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Risks associated with people's care needs were not consistently assessed, updated or met which impacted on people's safety. Guidance was not consistently provided to staff about people's health conditions and how this impacted on their care. For example, one person had a diagnosis of Parkinson's disease and another person had diabetes, risks associated with these needs had not been assessed or planned for. One person had high blood pressure, their daily care records showed on occasions staff checked and recorded this. This care task was not included in their care plan or risk assessment so did not have guidance on how to do this safely. A lack of guidance and clear instruction for staff put people at risk of unsafe care.
● People did not receive safe and timely care. There were at least 31 occasions since the last inspection when calls were missed. At least four people received support from one care worker when their assessed needs required two staff to provide safe support. We found evidence at least one person experienced harm because of this when they had a fall during a care visit. However, they did not sustain any injury.
● At the time of this inspection, the local authority had suspended their contract for new referrals and had moved a high number of people to different care agencies due to concerns about risks and safety.
● People did not always receive calls for the assessed duration which placed them at risk of having insufficient and unsafe care. One person's daily call logs showed five calls out of 12 were completed in five minutes or under and the longest call was 13 minutes. Whilst the registered manager told us the person

sometimes did not want staff present, the daily call logs did not reflect this.

The provider's failure to ensure risks were mitigated to ensure people's safety placed people at risk of avoidable harm. This was a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● A high number of staff had left working for the service, this meant there were insufficient staff available to meet people's care needs. This impacted upon people's safety. Since the last inspection, the registered manager told us 82 staff had left. This had a significant impact on staff deployment and led to calls being missed and/or late.
● People were put at increased risk because they experienced late or missed calls. One person told us they were supposed to receive four calls a day but how the last call was frequently missed. Another person said, "Probably a couple of times a week they (staff) are late." Daily logs confirmed frequent late calls. This put people at increased risk.
● Recruitment checks were completed before staff commenced their role, but probationary meetings to consider whether an employee was meeting standards and expectations did not take place. Staff gave mixed feedback about the quality of training. Whilst some staff felt training was adequate, others raised concerns. One staff member said, "No, we had no beneficial training. We just sat and watched DVDs and a bloke just said if we didn't do things right, we could go to prison." Staff did not receive consistent support to enable them to safely and effectively meet people's care needs.

The provider's failure to deploy staff appropriately and to complete probationary meetings and effective supervision was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People did not always receive support with their medicines from sufficiently trained staff. The registered manager told us all staff had received training in the administration of medicines. Four staff told us they had not received this training but had shadowed other staff to learn what was required. The staff training plan showed staff had received medicines training, but six staff were overdue their competency observations. Following the inspection, the registered manager confirmed these competency checks had been completed.

● Best practice guidance for medicines management for people receiving social care in the community was not followed. The registered manager told us they were receiving support and guidance from the local authority to make the required improvements.
● People did not consistently receive support with medicine administration on time which meant they were at increased risk of physical harm. Feedback and records confirmed this.

Preventing and controlling infection
● The training matrix showed staff had received infection and prevention control training. However, staff reported this was not specific to COVID-19, but the registered manager had sent staff emails advising staff of the action required in the management of this infection.
● Staff were provided with personal protective equipment and participated in the COVID -19 testing programme. People told us staff wore PPE when providing care.
● The provider had policies and procedures in place. Since the last inspection these had been improved and contained COVID -19 best practice guidance and staff were following this guidance.

Learning lessons when things go wrong

● Since the last inspection, some action had been taken to improve learning from incidents. For example, incidents were reviewed and analysed for themes and patterns. Whilst we saw some learning examples such as changes to call times and/or care plans and risk assessment updated, further improvements were required. Improvements had not been fully embedded or shared with the staff team and were not reflected in the provider's current action plan.

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 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.

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

At our last inspection, the provider's governance arrangements were not always effective or sufficiently proactive to consistently ensure the quality and safety of people's care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had also not notified the Care Quality Commission of incidents they are legally required to report. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The provider failed to ensure people received safe care and support. Action was not taken by the provider to ensure calls took place consistently, were on time and lasted the assessed duration. Staff were not deployed to meet people's needs safely using the correct number of staff. The provider failed to monitor, manage and mitigate risks safely and effectively.
● The provider failed to ensure people received a service of sufficient quality and safety. Since our last inspection there had been a high number of complaints. These were received from people who used the service, relatives or external professionals and staff. Complaints related to late and missed calls and staff not feeling supported.
● Feedback from staff during this inspection and from reviewing exit interview records, identified reoccurring concerns and dissatisfaction with work. This related to poor communication and organisation, lack of professionalism, management bullying, high volume of calls with limited breaks and concerns with pay and travel.
● Management oversight and accountability was ineffective. The provider's action plan was not sufficiently robust to assure us risks were effectively assessed, monitored and mitigated in a timely way. Actions did not reflect the findings and breaches in regulations identified at the last inspection. There was no significant evidence of actions in response to the high number of missed calls, substantiated safeguarding outcomes and complaints received.
● The provider told us they had voluntarily handed care packages back to the local authority to reduce risks. However, due to continued concerns about risks and safety, the local authority had transferred a high number of people to alternative care agencies to mitigate further risks. Whilst this had assisted in reducing the level of risk, continued concerns were identified and raised with us about the quality of care provided.

● Processes in place to monitor and assess staff practice were ineffective.  For example, spot checks were used to check staff practice. However, they did not identify the significant concerns of poor care found on this inspection.
● The provider's systems and processes were not sufficiently robust. Medicines management and procedures did not follow best practice guidance. The electronic system used to monitor calls and share information and guidance was not effective. Staff deployment was not managed effectively resulting in missed and late calls.
●The registered manager had not fulfilled their role and responsibilities due to being out of the office providing care. Whilst the provider told us there had been regular management meetings since our last inspection, meeting records from June 2021 could only be shared as there were no records of meetings before this date. These examples show poor management, leadership and oversight.

At this inspection, we found the provider had not made sufficient improvements and remained in breach of regulation 17.

● The provider had failed to notify the Care Quality Commission of missed calls and calls where lone workers had provided care instead of the required two care staff.

At this inspection, we found the provider had not made sufficient improvements and remained in breach of regulation 18.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had not received consistent person centred care and this had a negative impact on them achieving positive outcomes. The local authority had transferred high numbers of people to alternative care agencies due to concerns about the quality of care people had received.
● Since the last inspection, well-being checks had been introduced for both care staff and people using the service. Records confirmed this and people told us they had been asked for their feedback about their experience of the service they received.
● Feedback from people who used the service was overall positive about the individual care staff who provided their care. People raised concerns about the management of the service.
● The registered manager told us they were in the process of reviewing people's care package. This included reviewing care plans and risk assessments, and this would be completed with the person and or their relative where required.
● Staff supervision and support had been impacted. The registered manager had not been available to fully and effectively support staff due to delivering care.
● Staff told us they did not feel valued or listened to and many staff had left the service due to concerns about the management of the service.

Working in partnership with others
● The provider and registered manager were working with the local authority safeguarding and support teams to address concerns and make improvements. This included an increase in monitoring by the local authority and the completion of an action plan to be followed.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not have sufficient staff deployed to meet people's needs. New staff had not received probationary meetings and staff had not received sufficient supervision.<br><br>Regulation 18 (1) (2) |

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The Provider had failed to notify all reportable incidents they are legally required to do.<br><br>Regulation (Registration) 18 |

**The enforcement action we took:**

NOP to Cancel Registration

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The Provider had failed to provide safe care and treatment. This had exposed people to significant risk that impacted their health, safety and well-being.<br><br>Regulation 12 (1) (a) (b) |

**The enforcement action we took:**

NOP to Cancel Registration

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The Provider had failed to protect people from abuse and ill treatment. Systems and processes to manage and learn from safeguarding incidents were not robust. This placed people at risk of harm.<br><br>Regulation 13 (1) (2) (3) |

**The enforcement action we took:**

NOP to Cancel Registration

| Regulated activity | Regulation |
| --- | --- |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have robust systems and processes in place to effectively assess, monitor and mitigate risks and improve the quality and safety of the service. This placed people at risk of harm.<br><br>Regulation 17 (1) (a) (b) (c) |

**The enforcement action we took:**

NOP to Cancel Registration