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Curae Home Care

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: Curae Home Care is a domiciliary care agency. It provides personal care to older people living in their own homes in the community. At the time of our inspection the service was supporting 22 people.

Rating at last inspection:
The last rating for this service was good (published 23 October 2019).

Why we inspected:
Prior to this inspection the CQC and Cornwall council's safeguarding team received significant information of concern about the service's performance. This included; reports of people's visits being missed and late, reports of staff being employed without Disclosure and Barring Service checks being completed and concerns about the providers performance.

People's experience of using this service:

We found the service was short staffed and there had been significant management changes since our last inspection. Both of the service's senior staff were on maternity leave and a new deputy manager had been appointed. However, both the provider and the deputy manager were routinely completing care visits as the service did not have enough staff available to provide all planned care visits.

People and staff reported there had been a recent decline in the service's performance and that planned visits had been missed, late and completed by insufficient numbers of staff. People's comments included, "Until recently they always turned up. We have had quite a few problems. It is not the carers it is the management" and "[The staff)] are a really good team, but the management is beyond shocking." Care plans and risk assessments showed people required support to access their medicines, manage their continence and to be repositioned to reduce risks of skin break down. Missed visits exposed people to risk of harm. It was specifically reported that the provider had failed to attend visits and staff told us, "I am not aware of any missed visits, other than the ones by the provider."

The service did not have systems in place to record details of missed visits, investigate why visits had been missed or to try to identify learning where things had gone wrong.

In addition, we found the provider had routinely failed to complete records detailing the care and support they had provided. This included failures to record details of support with medicines. People were exposed to risk as it was not possible to establish what care had been given by the provider.

The service's recruitment processes were unsafe. Necessary checks had not been completed to ensure prospective staff were suitable for employment in the care sector.

The provider was disorganised and unreliable. They did not give effective leadership to the staff team and their poor practice did not encourage staff performance. The provider failed to meet inspectors at agreed times on each of the three inspection days.

The CQC had significant concerns about the service, we wrote to the provider on the last day of our inspection requesting an action plan detailing what steps the provider intended to take to ensure people safety. The provider failed to respond to this request within the set timescales.

Enforcement: We found breaches of regulation. Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals 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.

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

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.

Curae Home Care

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
Two inspectors completed this responsive inspection.

Service and service type: Domiciliary care agency
This service is a domiciliary care agency. It provides personal care to predominantly older people living in their own houses and flats in the community.

CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the beginning of the inspection 22 people were receiving support from the service.

The service is not required to have a manager registered with the Care Quality Commission. This is because the provider is registered as an individual and is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was announced as we wanted to ensure someone would be available to assist us during the office visit. On arrival on the first day of the inspection despite this announcement we found that the office was closed and no staff were available to facilitate the inspection process. On both subsequent days of the inspection the provider failed to meet inspectors at agreed times.

What we did before the inspection:
We reviewed the records we held on the service. This included reviewing notifications. Notifications are specific events registered people have to tell us about by law. We also reviewed details of a number of safety

concerns about the service's performance that had been received by CQC and Cornwall Council's safeguarding team.

During the inspection:
As we were unable to access the service's office on the first day of our inspection we spent time speaking with people and staff via telephone. In total we spoke with nine people, three relatives and six members about the service's performance.

On the second and third days of the inspection we spoke with an additional member of staff, the deputy manager and the provider. We inspected five people's care plan and four staff recruitment files. We also reviewed the service's; call monitoring data, daily care records and policy documentation.

After the inspection
We reviewed documentation gathered during the inspection process and contacted the provider to seek clarification on the measures they intended to introduce to urgently improve the service's performance.

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.

Staffing and recruitment

- The service's recruitment processes were unsafe. Necessary recruitment and pre-employment checks had not been completed for recently appointed staff.
- One staff member who was regularly working alongside the provider in people's homes, did not have a staff file. The only documentation available in relation to this individual was a partially completed application form. This did not include the staff member's full employment history and references had not been requested.
- Disclosure and Barring Service checks had been requested for this individual and the DBS service had warned the provider on 30 August 2019 not to make any appointment decisions in relation to this individual before viewing their disclosure certificate. These checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The provider confirmed they had not seen the disclosure certificate but had allowed the staff member to accompany them on care visits. No risk assessments had been completed in relation to this staff member's continuing employment. This failure meant people using the service were significantly and unnecessarily exposed to risk.
- Other staff records showed complete employment histories were not required as part of the service's recruitment practices and that decisions had been made to appoint staff despite evidence of prior poor performance in the care sector.

Necessary checks had not been completed to ensure all staff were suitable for employment in the care sector. This meant the service was in breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service was understaffed at the time of our inspection.
- Records showed staff were regularly working more than their contracted hours. Both the provider and deputy manager were routinely scheduled to provide care visits. Staff said, "We are short staffed", "[There are] not enough staff to cover rota, especially at weekends" and "The service could do with more staff but they are trying to recruit." The provider told us, "We are so short staffed at the moment. This has never happened before."
- People told us the timing of their visits had recently become erratic. Their comments included, "Yesterday they were very late. By the time they helped me up to have breakfast it was time for lunch", "Two visits [in the last fortnight] were over an hour late" and "Things have got bad in the last two weeks. Always late by at least an hour in the morning and very late for the evening call."
- Relatives also confirmed this decline in the service's performance. They told us, "The girls are great, the timing could be better. We had a no show (missed visit) last month. That was the first one ever, it was bad

last month" and "They send us an email [detailing planned visits times] but that is just pointless as you can never rely on them."

Current staffing levels were insufficient to meet people's support needs. This meant the service was in breach of the requirements of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People were at risk of harm because they did not always receive the care and support they needed. People and relatives reported that numerous planned visits had been missed in recent weeks. Their comments included, "[On specific dates] in August they missed two early visits. They just did not turn up" "Missed visits happen occasionally. Sometimes they are just too busy to come here. It has happened a bit more frequently recently, once or twice a week" and "Until recently they always turned up. We have had quite a few problems. It is not the carers it is the management."

● Staff recognised that visits had been missed and that some visits to people with complex care needs, requiring support from two staff, had been completed by one member of staff. They told us, "[On a specific day] I had to do a double handed shift on my own. I could not transfer people" and "I know a lot of calls are being missed."

● People's care plans and risk assessments showed they were at risk of harm if planned support was not provided. We found visits had been missed to people who were unable to access their medicines independently and at significant risk of skin breakdown if they were not supported to reposition themselves or assisted to manage their continence.

● People and staff consistently reported that where a visit had been missed this was because the provider had failed to attend. One person told us, "[The provider] was meant to come over first thing the other morning but did not turn up." While staff comments included, "[The provider] is not turning up to the calls she is supposed to", "[The Provider] was meant to be there but she does struggle with the times, I don't know why" and "I am not aware of any missed visits, other than the ones by the provider."

● Neither the provider or the deputy manager were able to provide an explanation as to why the provider had failed to attend allocated visits. We asked the provider about why specific visits had been missed. The provider was unable to provide specific details but commented, "The other missed calls are just when I am late, I call up and people say not to visit."

● The service used mobile phone-based technologies to enable staff to record when they arrived at and left each person's house and a separate system to digitally record details of the care and support they had provided during each visit.

● We reviewed the service's rotas and data from the call monitoring and digital daily care record systems to try to establish the number of care visits that had been missed. We found the provider had not been recording details of their arrival and departure time to each planned visit or any information about the care they had provided. The service could not establish which of the 42 visits the provider had been scheduled to deliver between 20 August and 05 September 2019 had been made.

● The provider's failure to use the available call monitoring and daily care records systems meant it was not possible for missed visits to be identified. The service's system for recording reports of missed visit were also ineffective.

People were not assured of receiving safe care, because of the failure to provide planned care visits and to documents what support had been provided forms part of the breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were complimentary of the service's other care staff and told us once staff arrived they normally received support visits of the correct duration.
● Care plans included risk assessments and staff had been provided with guidance on how to protect both people and them from identified areas of risk. However, these were not always updated as people's needs changed. One person was described in their daily notes as receiving palliative care. Their care plans and risk assessments had not been updated to guide staff how to meet their needs.

Using medicines safely
● People were not always supported safely with their medicines. Medicines administration records (MARs) were not consistently completed. It was not possible to establish from records that people had been safely supported with their medicines by the provider as records had not been completed.
● Some people required their medication at specific times and the recent unreliability of the service's visit times meant these needs had not been met. One person told us, "I wait up for them, I can put myself to bed but I wait up for my meds."
● There was a lack of formal auditing of medicines records and where MAR charts were not been completed these issues had not been addressed.

These failure in relation to the support people received with medicines form part of the breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● There were no procedures in place for the recording and investigation of reported missed visits.
● The service did not ensure lessons were learned when things went wrong and did not have systems in place to ensure reported safety concerns ware addressed. For example, one staff member had advised managers that they had not yet received any moving and handling training. This information had been recorded but no action taken to address and resolve the situation. This failure unnecessarily exposed people and staff to risk of harm.
●Some people were at risk of skin break down and damage. One person had recently developed a sore which was now being treated by specialist community nursing teams. Some information about this injury was recorded in daily care records. However, there was no information available detailing when this injury had initially been identified or of when staff had reported their concerns to health professionals.

The failure to learn from incidents meant people were exposed to ongoing risk of harm as no action had been taken to prevent similar events reoccurring. This forms part of the breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Staff had some understanding of local safeguarding procedures but reported they had not received recent refresher training in this area. Staff told us they would report any concerns in relation to people's safety to the local authority or the commission. Prior to this inspection concerns had been reported anonymously to both authorities about the service's current performance.
● People told us they felt safe while staff were visiting. People's comments in relation to the staff team included, "I think my carers are wonderful", "The staff are lovely" and "Our regular carer is marvellous."

Preventing and controlling infection

- Protective equipment including gloves and aprons was available from the service offices.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- People and their relatives were concerned about the service's management. They told us, "[The staff)] are a really good team, but the management is beyond shocking", "It is not very well managed" and "It's just badly managed that is all, it could be better managed."
- Staff also recognised that there was a lack of leadership in the service and told us this had impacted on both their morale and the service's performance. Staff commented that, "The management is shocking" and "I don't like working for the company anymore."
- The provider did not have a good understanding of the regulatory requirements and was unreliable in her dealings with the commission during this inspection. Despite having announced the inspection and made arrangements to meet with the provider on the first day of our inspection we were unable to gain access to the service's offices. On both of the following inspection days the provider failed to attend the office at agreed times.
- Significant concerns were identified during the inspection in relation to the service's performance. The CQC was concerned people were unnecessarily exposed to the risk of harm because of the service's unreliability and use of inappropriate staff. As a result, on the last day of the inspection the CQC wrote to the provider to request an urgent explanation as to how they intended to address and resolve these issues. A response was required by 9 September.
- The provider failed to respond to the commission's letter and did not produce any information within the agreed timescale. In addition, the provider failed to contact the commission at the agreed time to discuss these plans.
- The commission subsequently contacted the provider by telephone and requested the required information. The provider reported their action plan had not yet been completed but was being worked on. The commission asked for the current draft of these documents be provided urgently but this was not done.

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 service had previously successfully used digital systems to ensure all planned care visits were provided and to records details of this support given by staff.
- These systems were still in use successfully by most staff. However, the provider was not using these systems and no alternate recording procedures had been introduced. This meant is was not possible to establish if visits, allocated to the provider, had been delivered or to find out what support the provider had given people.

● During the inspection we identified an occasion where the provider had made changes to the service's rotas at extremely short notice which meant it was impossible for people's needs to be met. Two minutes before the provider was due to arrive at a person's home she had transferred this visit to another member of staff. This staff member was already scheduled to be providing care for another person. This meant they were supposed to be supporting two people at different addresses simultaneously. The provider's action in rescheduling visits at extremely short notice directly exposed people to risk of harm.
● Where visits were late or missed the provider did not give people candid explanation as to why this had occurred, and investigations had not been completed to identify why visits had been missed. People told us, "[The provider] apologises for being late but does not explain why" and "There is always something going on to explain why they were late."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People had noticed a significant decline in staff morale and commented, "The carers are friendly and polite, but morale is a bit low at the moment".
● Staff told us they were unable to rely of the service's on call management arrangements and instead had to contact the deputy manager directly if they needed support or guidance during a care visit.
● Staff spoke positively of the service's deputy manager who they said was supportive and had ensured rotas had been regularly updated. Staff told us, "[The deputy manager] is brilliant. Staff know where they need to be" and "[The deputy manager] does the rotas, she is amazing."

Continuous learning and improving care
● The provider had not used the systems and information available to them to learn from incidents and improve the service's performance.
● Audits were ineffective and the service's quality assurance systems had failed to ensure compliance with the requirement of the regulations.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There had been significant changes to the service's leadership since our last inspection. Previously the provider was supported by two senior members of staff who were normally office based. Both these staff had temporarily left the service prior to this inspection. A new deputy manager had been appointed but told us, "At the moment, I'm mainly a carer but I've been doing the rotas in my free time."
● The provider was not giving effective leadership to the staff team. Their actions and failures to attend planned care visits had exposed people to risk of harm.
● The service's recruitment practices were unsafe and necessary pre-employment checks had not been completed.

The provider had failed to adequately assess and monitor the quality and safety of the service people received. The staff team had not received effective leadership and the service did not operate appropriate systems to ensure compliance with the regulations. This was breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were no clear processes or procedures in place for engaging with people or staff. Staff told us, "We

don't have many team meetings. The only communication we have is with colleagues on doubles or by phone calls."

● The service's offices were not normally open to staff or the public as managers currently spent their time delivering care visits.

● Staff respected the people they supported and ensured they were protected from discrimination.

Working in partnership with others

● The service did not have robust systems in place to ensure information reported by staff to management was shared with health professionals.

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 Care visit had been missed and the provider had failed to document the care they had given and the support people had received with their medicines.

The enforcement action we took:

We urgently suspended the service's registration for four months.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service's system for ensuring compliance with the regulations were ineffective.

The enforcement action we took:

We urgently suspended the service's registration for four months.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service had failed to ensure staff were suitable for employment in the care sector.

The enforcement action we took:

We urgently suspended the service's registration for four months.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not employ sufficient staff to meet people's needs.

The enforcement action we took:

We urgently suspended the service's registration for four months.