

Carebright Evesham Limited

Carebright Evesham

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Carebright Evesham is a domiciliary care agency and supported living service providing personal care to people living in their own homes. There were four people using the service at the time of inspection. 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 and what we found

Quality assurance processes were ineffective. There was a lack of management oversight of the service being provided. Systems, processes and checks had failed to identify the shortfalls we identified during our inspection visit.

Risks to people's safety was not well managed which placed people at risk of harm. People were not always supported by staff that had received the necessary training to meet their needs. Care plans were not always being followed including medicine administration and management.

Some people using the service told us they were not happy about their care and support they received. People were not always supported to attend health appointments.

People were not supported by staff to keep their home clean and well kept.

Staff were not always being recruited safely. Checks made prior to employment had not always been carried out to ensure staff were of good character before working with vulnerable adults which could impact on the safety of people who used the service.

People were supported to have maximum choice and control of their lives and staff did support them in the least restrictive way possible and in their best interests; the policies and systems in the service did support this practice.

Safeguarding procedures were in place to protect people.

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

Rating at last inspection

This service was registered with the Care Quality Commission on 28 November 2019 and this was the first inspection.

Why we inspected

We undertook a focused inspection to review the key questions of safe, effective and well-led only. We reviewed the information we held about the service.

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 monitor the service and 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 keeping people safe in relation to their medicines, risks and care planning as well as the governances of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 for 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.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

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 ●

Carebright Evesham

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

The inspection was carried out by two inspectors.

Service and service type

This service is a domiciliary care agency and supported living service. It provides personal care to people living in their own homes. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

At the time of the inspection the service did not have a manager registered with the Care Quality Commission. This means the provider is 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 and took place on 19 November 2020.

What we did before the inspection

We reviewed information we held about the service. We sought feedback from the local authority and professionals who work with the service. We also requested feedback from Healthwatch to obtain their views of the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our 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.

During the inspection

We spoke with four people who used the service about their experience of the care provided. We spoke with five members of staff including the provider, senior care worker and care workers.

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

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records sent to us by the provider.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Medicines were not always managed safely and recorded accurately. People who required assistance with their medicines could not be assured they would always receive these as prescribed. This placed people at risk of not having their health care needs met.
- We observed a staff member telephone through to a person using the service and asked them if another person using the service had taken their medicines. This was not in line with people's care plans which stated, "Staff are to observe [person] taking their medicines". Therefore, staff could not be assured people had taken their medicines placing them at risk and having an adverse effect on their health conditions.
- There were ineffective protocols and procedures for the administration of PRN medication when there were no staff on site. PRN medicines are taken 'as and when needed'. For some of the people using the service these medicines were stored in the office. This meant there was a potential risk of people not having their medicines when they required these to meet their health needs.
- Medication audits had been carried out. However, we could see no evidence of any audit having taken place since 24 August 2020. This is not in line with the provider's medication management policy which states, "Every month senior staff will conduct an audit on the preceding months activities". This could potentially have an impact on people as without audits medicine errors may not be always brought to the attention of the management team so any areas for improvement to safeguard people from avoidable harm would not be identified.
- People told us they were not always happy with the way their support was delivered. For example, one person told us staff did not always communicate to them in a way they could understand. The person told us, "This makes me angry".
- Risks that had been identified for people using the service contained little guidance on how to prevent the risk. We could not see whether risks had been regularly reviewed to ensure any changes in people's support were explained, together with measures for staff to follow to promote people's safety. This increased the risk of people receiving unsafe care.
- Records showed staff were not following some people's individual protocols. For example, when an ambulance should be called in line with a person's epilepsy management plan. Failure to follow protocols could potentially put someone at risk of serious harm.
- Incidents were not always identified so lessons could be learnt to drive improvement.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate risk was effectively managed. This placed people 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.

Staffing and recruitment

- The provider was not always following safe recruitment processes and staff were not always recruited with the required checks being undertaken, to protect people from the risk of harm and abuse. For example, not all staff files included an employment history and references to ensure staff were of good character to work with vulnerable people.
- We found no evidence of all staff's disclosure and barring service [DBS] check on file. A DBS check is a legal requirement and is a criminal record check on an individual. These checks help providers make safer decisions when employing staff to work with vulnerable people.

We shared our concerns with the provider. Since our inspection the provider has sent us copies of completed DBS checks for staff. They also told us their future plans in relation to medicine management and recruitment processes.

Preventing and controlling infection

- People told us they were not always supported with cleaning of their personal areas as per their care plans putting people at risk of cross infection.
- Staff told us they had access to personal protective equipment [PPE] such as gloves and masks.
- Staff wore PPE in line with current guidelines.

Systems and processes to safeguard people from the risk of abuse

- Staff told us they recognised signs of abuse and how to report any concerns.
- Staff told us they would report incidents of potential abuse to the senior staff member or higher management.

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.

This is the first inspection for this newly registered service. This key question has been rated 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 were not provided with appropriate training necessary to meet the needs of people they supported. For example, not all staff had received training in epilepsy, diabetes and behaviours that challenge. The provider had failed to ensure staff had the skills and knowledge to meet people's needs.
- A staff member told us, "I've not received any positive behaviour training, but I know what to do", when asked to give further details they replied, "From other staff telling me what to do". Therefore, the provider could not assure themselves staff had the knowledge and skills to work safely and effectively with people whose behaviour may challenge.
- New staff told us they had not completed the Care Certificate since starting their employment. The Care Certificate is a set of standards that health and social care workers can work in accordance with. It is the minimum standards that should be covered as part of the induction training of new care workers.
- Staff told us, they had not had regular supervisions and the opportunity to discuss performance and training needs.

The failure to ensure staff were trained to competently perform their roles had placed people at risk. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider gave us assurances following our visit they would source training for all staff and ensure any new staff are provided with appropriate training necessary to carry out their role.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People told us they did not receive the support they needed. One person told us staff did not support them to an appointment as, "They [staff] said they were too busy to go" and "They [staff] cancelled another health appointment twice". Another person told us, "They [staff] would not go the shop to purchase food for me".
- People's needs had been assessed before they moved in to the service. However, the paper work was not dated therefore we could not see any evidence reviews had taken place to ensure people's individual ongoing needs continued to be met.
- Care plans did not include any information regarding contingency plans for when staff are not available. For example, the provider does not have a current on-call rota so people were able to ask for assistance and or check something if they required this. People told us when they needed the on-call service on occasions the telephone was switched off.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us they were no longer receiving support from staff with cooking a healthy meal. One person told us, they were not always given the opportunity to menu plan, staff would just offer one meal choice which restricted their nutritional intake.
- Staff told us since the start of the pandemic they have only provided assistance with placing food in and taking food out of the oven. However, people's care plans had not been updated to reflect this change. One person complained about the standard of food preparation stating it was often undercooked or burnt on occasions.

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 their health appointments despite being a requirement in someone's care plan. For example, one person told us, they had requested staff support to attend a routine health appointment and was told there were no staff available on two separate occasions. Therefore, the provider could not assure themselves people's health needs and support were being met.

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 using the service had capacity to make their own decisions.
- Staff understood the need to respect and support people's right to make their own decisions. People's care plans reminded staff of the importance of offering each individual choices in relation to their care.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Prior to this inspection visit we received information of concern that the service was not well-led and people were not receiving positive outcomes as a result. Two people told us they were so unhappy with the care and support they were planning to leave the service.
- Since registration of the service there have been several different managers. There was no manager in post at the time of this inspection. We discussed this with the provider, they told us they were currently advertising for the position. The provider told us there was a management plan in place to support staff for the interim period which consisted of the provider having oversight of the service. Staff told us the provider visits once a week and is always available via the telephone.
- There was a lack of audits and any audits that had taken place were not effective. For example, infection control and health and safety audits had failed to identify the poor standards identified at the inspection. There were no provider audits to show they had taken place to identify shortfalls and monitor any actions required putting people at risk of harm.
- Medication management did not follow best practice guidelines. The provider had failed to ensure the system to monitor medicines administration was effective. The provider had an audit process in place, however this had failed to identify the concerns we found, a lack of guidance for administration, placing people at risk of harm.
- We found shortfalls whereby people's risk plans had not been reviewed to reflect people's care and support needs. This meant staff may not always have accurate information to follow in terms of consistently supporting people's individual needs.
- The provider operates a facility in relation to on-call support after office hours. However, one person told us, when they dialled the on-call telephone number on several occasions the number was unavailable. When we brought this to the provider's attention, they told us they would investigate this.

The provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Following this inspection we had a provider meeting to discuss our findings. The provider acknowledged

the concerns we raised. The provider sent a plan of action of improvements they intended to make [this included staff training and reviewing recruitment processes] and to assure themselves people were safe, and care was of a high quality.

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

- The provider failed to seek feedback from the people using the service. We could not see any evidence of customer satisfaction surveys being conducted. Therefore could not identify any areas for improvement.

Working in partnership with others

- Staff did not always work effectively with health and social care professionals to ensure good outcomes for the people living at the service. For example, people's health appointments had been missed. Staff told us they hadn't been notified of the appointment and as soon as they were made aware the appointment was rebooked.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe management of medicines |
| Regulated activity | Regulation |
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff had the necessary training to support people's needs. |

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 17 HSCA RA Regulations 2014 Good governance Governance systems or processes were not in place to ensure compliance with the requirements in this regulation. |

The enforcement action we took:

A warning notice was served against the registered provider.