Mars Cheshire Limited

Caremark (Cheshire North East)

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 December 2014. A second day of the inspection took place on the 9 December 2014 in order to gather additional information.

We found that the service was not always safe or well led as double-up calls (visits that should be undertaken by two staff) were sometimes being undertaken by one carer. Furthermore, some people did not have risk assessments on specific areas of need such as pressure care or nutrition and the agency did not have a comprehensive medication audit in place to monitor and identify issues with medication promptly. Some concerns were also raised regarding a lack of continuity of care staff deployed by the agency. There was no management information in place to enable us to analyse the frequency of events such as the reason why double up calls had not been completed or the action taken by the manager in response to such incidents.

Furthermore, although systems were in place to seek feedback on the standard of service provided to people using the service, there was no action plan in place to demonstrate how the service planned to address constructive feedback to ensure the ongoing development of the service.

Following completion of the inspection in December 2014, the Care Quality Commission received information of concern from the relative of a person who had

Summary of findings

previously used the service. The person raised concerns regarding the agency, inspection process and the accuracy of some of the information contained within the inspection report.

A focussed / follow up inspection was therefore undertaken on 19 June 2015 in response to the information of concern received and to follow up on action taken since the last inspection. You can read a summary of our findings below.

This report only covers our findings in relation to this focussed / follow up inspection. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for 'Caremark (Cheshire North East)' on our website at www.cqc.org.uk.

Caremark (Cheshire North East) is a domiciliary care service that is operated on a franchise basis and is part of a network of other branches of Caremark that operate in Great Britain.

The agency offers personal care to people with a range of needs within their own homes and in their local communities. Their office is based in Handforth, Cheshire and covers Handforth, Wilmslow, Alderley Edge and Knutsford. At the time of our inspection the service was providing the regulated activity of 'personal care' to approximately 54 people.

The agency's registered manager has worked in this role for approximately 2 1/2 years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our focussed / follow up inspection on 19 June 2015 we found that the provider had taken action to develop management information systems, improve the reliability and flexibility of the service and with the introduction of quality assurance, summary reports.

However there was scope for further development of risk assessments; medication auditing and records relating to Mental Capacity and Lasting Power of Attorney.

We also found a breach of the Care Quality Commission (Registration) Regulations 2009 regarding the reporting of notifiable incidents. You can see what action we told the provider to take at the back of this report.

Summary of findings

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.

There was further scope for the development of medication audit records completed by staff and management to ensure a clearer audit trail.

Requires improvement

Is the service well-led?
The service was not always well led.

Incidents that should be notified to the Care Quality Commission had not always been reported.

Requires improvement

Caremark (Cheshire North East)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 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 Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook a focussed / follow up inspection of Caremark Cheshire North East on 19 June 2015. This inspection was completed in response to information of concern received and to follow up on action taken since the last inspection.

We inspected the service against two of the five questions we ask about services: Is the service 'safe' and 'well led'. This is because we had reason to believe the service may not have been meeting legal requirements in relation to these questions.

The inspection was undertaken by one adult social care inspection manager and one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the provider's action plan which set out the action they would take to develop the service and the concerns we had received from the relative of a person who had previously used the service.

At the time of the inspection we spoke with the registered provider and registered manager. We looked at care records for four people; complaint logs; incident and accident records; management information; staff records and audit documentation.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Caremark Cheshire North East on 08 and 09 December 2014 we found that people requiring double-up calls were sometimes receiving support from one carer.

Also at the last inspection we noted that some people did not have risk assessments on specific areas of need such as pressure area care or nutrition. Likewise, some people were not adequately protected from the risks associated with unsafe medicines management as the agency did not have a comprehensive medication audit in place to monitor and identify issues.

At our focussed inspection on 19 June 2015 we found that the registered manager had introduced a new form to monitor information and issues related to the receipt, recording, storage, administration and disposal of medication.

We noted that staff had not always recorded dates correctly and ticked some sections of the form rather than recording information within each section. There was also no space for staff to date and sign the form and limited space to record information. We also found that a separate audit tool had not been established to verify that the registered manager had audited records.

We informed the management team of concerns that had been brought to the attention of the Care Quality Commission following completion of the last inspection by a relative of a person who had previously used the service.

For example, we informed the management team that concerns had been expressed that some staff may have been working for the agency without a Disclosure and Barring (DBS) certificate. The registered manager was able to provide evidence that she had maintained a register of DBS checks for all staff and confirmed that no staff commenced employment until the outcome of a DBS check was known.

We looked at four care files and found them to be well organised and easy to follow. Files viewed contained: individual care and support agreements; individual needs assessments; risk assessments and medication records (where applicable). A range of supporting documentation was also available for reference such as: customer contact sheets; a statement of purpose; complaints policy; customer contract; individual reviews; log sheets and other miscellaneous documentation.

In one file we found that a Medication Administration Record provided no explanation of why a particular code had been used.

We recommend that a separate medication audit tool be established to verify that the registered manager had audited records.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Caremark Cheshire North East on 08 and 09 December 2014 we found that there were no management information systems in place to enable us to analyse the frequency of events such as the reason why double up calls had not been completed or the action taken by the manager in response to such incidents.

Furthermore, although systems were in place to seek feedback on the standard of service provided to people using the service, there was no action plan in place to demonstrate how the service planned to address constructive feedback to ensure the ongoing development of the service.

At our focussed inspection on 19 June 2015 we found that the registered manager had introduced a management information file which contained a record of any missed calls or double-up visits, reasons for any occurrences and action taken.

Furthermore, we noted that the registered manager had introduced a 'carer audit information' record to capture information on spot checks; refresher training; observations and supervision dates. Likewise, a 'client audit information' sheet had been established to record the dates when quality assurance checks, individual reviews and telephone monitoring visits had been undertaken.

Additionally, the registered manager had introduced a tracking form for complaints which outlined an index number, date of complaint; name of complainant; details of complaint; date an acknowledgement letter was sent; action taken and outcome. A separate audit form had also been established for incidents and accidents.

We looked at four care files which were found to contain evidence of regular contact between senior management and clients, including quality assurance reviews, telephone monitoring and individual reviews. The registered manager demonstrated a good knowledge of specific clients and their care packages and was very committed to working flexibly with individual clients using their personal budgets to maximum benefit.

We queried why some actions identified as being required on quality assurance forms hadn't been signed off as having been done. The registered manager explained that actions would have been taken at the time the form was completed and the records updated in the working file kept at the client's home. However, there was nothing in the file in the office to record what action had been taken.

We noted that a basic action plan had been developed to demonstrate how the service planned to address constructive feedback and findings following the customer surveys distributed to people using the service and / or their representatives during August 2014. However, there was no action plan for the surveys returned by staff. The Care Quality Commission received a comprehensive action plan to address feedback from the customer feedback and staff survey a week after our focussed inspection.

We informed the management team of concerns that had been brought to the attention of the Care Quality Commission following completion of the inspection by a relative of a person who had previously used the service.

For example, we informed the management team of an accident that had allegedly occurred in May 2013 when a service user sustained a fall and injuries whilst in the process of being hoisted. The registered manager confirmed that an incident of this nature had occurred and that an accident form had been completed. The management team reported that they had not notified CQC of the incident as the incident had gained severity over the following days and the service was not involved or kept up to date on the medical intervention that the service user had received or indeed the severity of the injuries sustained.

We raised concern that having reviewed the accident and incident file there were other incidents that should have been notified to CQC. For example, an event in January 2015 involving the police that should have been reported via a statutory notification.

We also explored a concern regarding the alleged absence of care plan documentation and associated records in some people's homes. The management team reported that care plans had previously been taken out people's homes in order that they could be updated and reviewed. We noted this practice had been stopped and that updated versions were now prepared at the office and delivered to people's homes. This ensured that a copy was in place at all times.

Furthermore, we highlighted to the management team that we had been informed by the provider that none of the

Requires improvement

Is the service well-led?

people using the service at the time of the last inspection lacked capacity. We raised concern that a relative had reported that a relative and other people using the service did lack capacity at that time and that the information within CQC's report was therefore not correct.

The registered manager confirmed that the person did lack capacity and that there had been no deliberate intent to mislead CQC. However the registered manager stressed that that there was no documented evidence as the individual had not been formally assessed under the Mental Capacity Act 2005. The CQC has received confirmation since the follow up inspection that the information received from Caremark Cheshire North East contained erroneous information.

We recommend that the agency review their records relating to Mental Capacity and any individuals with Lasting Power of Attorney to ensure accurate records are maintained.

We recommend that any actions undertaken as a result of quality assurance checks are recorded on the relevant master forms to provide a robust audit trail

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had failed to notify the Commission without delay of incidents which had occurred whilst services were being provided in the carrying on of a regulated activity or as a consequence of the carrying on of a regulated activity.