

R K S Domiciliary Care Ltd

# Caremark -Charnwood

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This was our second comprehensive inspection of Caremark - Charnwood. The visit was announced and was carried out on 7 January 2019. The provider was given notice because the location provides a domiciliary care service. We needed to be sure someone would be in the office. The service provided domiciliary care and support to people living in and around the town of Loughborough, Leicestershire. At the time of our inspection there were 61 people using the service.

Not everyone using Caremark - Charnwood received the regulated activity; personal care. CQC only inspects the service received by people provided with personal care, help with tasks related to personal hygiene and eating. Where they did we also took into account any wider social care provided. Of the 61 people using the service, 57 were receiving the regulated activity, personal care.

At our last inspection in May 2016, the service was rated overall 'Good'. At this inspection we found the service 'Required Improvement'.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The provider's safeguarding processes had not always been followed by the management team when a safeguarding allegation had been received.

Whilst the risks associated with people's care and support had been identified, not all had been included in the risk assessment process. Risk assessments seen were generic in content and lacked personalised information.

Whilst auditing systems were in place, these did not always pick up omissions within the documentation held at the service.

Whilst the majority of people received the calls they required, we evidenced one occasion when a person's call, which was mainly to prompt them to take their medicines, had been missed.

People and their relatives told us they felt safe with the staff who visited them. Staff had received training on the safeguarding of adults and knew what to do if they were concerned for someone's welfare.

Appropriate checks had been carried out when new members of staff had been employed to make sure they were suitable to work at the service. Staff members had received an induction into the service and relevant training had been provided to enable them to meet people's needs.

The staff team had received training in the management of medicines. Where people required support with their medicines, they were supported in line with the provider's medicines policy.

People were supported to maintain good health. They were supported to access relevant healthcare services and they received on-going healthcare support. People who required support at mealtimes were supported to have enough to eat and drink to keep them well.

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

The staff team had received training in infection control and understood their responsibilities around this. People were protected by the prevention and control of infection.

The staff team were kind and caring and treated people with dignity and respect. People were supported to make choices about their care and support on a daily basis.

There were arrangements in place to make sure action was taken and lessons learned when things went wrong and a business continuity plan was available to be used in the event of an emergency or untoward event.

Whilst the staff team had received training on the Mental Capacity Act 2005 (MCA) not all could remember completing this. People's consent was always obtained before their care and support was provided. The management team understood the principles of the MCA.

We recommend all staff receive training in and are reminded of the principles of the Mental Capacity Act (MCA) 2005.

Plans of care had been developed with the people using the service and their relatives. This enabled the management team to identify their individual care needs and provide support in a way they preferred. An end of life care policy was in place for the staff team to follow.

The staff team felt supported by the registered manager and the management team and told us there was always someone to talk to if needed.

People had the opportunity to be involved in how the service was run. They were asked for their opinions of the service on a regular basis. This was through care reviews and through the use of surveys.

A formal complaints process was in place and people knew who to talk to if they had a concern of any kind.

The provider and registered manager were aware of their registration responsibilities including notifying CQC of significant incidents that occurred at the service.

Further information is in the detailed findings below.

## 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 consistently safe.

The provider's safeguarding processes had not always been followed.

Risk assessments did not always reflect people's current needs.

The provider followed appropriate recruitment processes to ensure only suitable staff worked at the service.

People were protected from the risk of infection.

Lessons were learned and improvements were made to the service when things went wrong.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

People's needs had been assessed before they started using the service.

People received care and support from a staff team who had the necessary knowledge and skills.

People received support to maintain a balanced diet.

Consent to people's care and support had been sought.

People's health and wellbeing were monitored and they were supported to access the necessary healthcare professionals when they needed it.

**Good** ●

### Is the service caring?

The service was caring.

People were treated with kindness.

People's care and support needs were met in a caring way.

**Good** ●

People were treated with dignity and respect and were involved in making decisions about their care and support.

### **Is the service responsive?**

The service was responsive.

People were involved in the assessment of their needs and the developing of their plan of care.

People's plans of care had been reviewed and the staff team knew people's care and support needs.

A formal complaints process was in place and people knew what to do if they were concerned or unhappy about anything.

An end of life care policy was in place for the staff team to follow.

**Good** ●

### **Is the service well-led?**

The service was not consistently well led.

Monitoring systems used to check the quality of the service being provided had not always identified shortfalls within the documentation held at the service.

People had been given the opportunity to share their thoughts on how the service was run.

The staff team working at the service felt supported by the registered manager and management team.

People told us the service was well managed and the staff team were welcoming and friendly.

**Requires Improvement** ●

# Caremark -Charnwood

## 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 is 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.

This inspection took place on 7 and 8 January 2019. The inspection was announced. We visited the provider's office on the first day of the inspection and members of the staff team and people using the service were contacted by telephone on the second day. The inspection was carried out by one 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. Their area of expertise was older people with dementia.

Before the inspection, we reviewed information we held about the service such as notifications, these are events which happened in the service that the provider is required to tell us about.

We contacted the health and social care commissioners who monitor the care and support of people receiving care from Caremark - Charnwood to obtain their views of the care provided. We also contacted Healthwatch Leicestershire, the local consumer champion for people using adult social care services to see if they had any feedback. We used this information to inform our judgement of the service.

We spoke with nine people using the service and one relative.

During our visit to the office we spoke with the managing director, the registered manager, the assistant manager, the care coordinator and one staff member. Four staff members were contacted by telephone following our visit to gather their views of the service.

We reviewed a range of records about people's care and how the service was managed. This included the plans of care of three people receiving care and support. We also looked at associated documents including risk assessments. We looked at the recruitment checks carried out for three staff members and the quality assurance audits the management team had completed.

## Is the service safe?

### Our findings

Risk assessments had been completed prior to people's care and support packages commencing. This allowed the management team to identify any risks presented to either the person using the service or the support workers during the delivery of their care. These included a safety risk assessment and a moving and handling risk assessment. We noted not all the assessments seen included person specific information and were more generic in nature. For example, one person's plan of care stated they should not be left with any hot drinks or anything sharp, this risk had not been identified or included in the assessment documentation. Another person's safety risk assessment stated they had bed rails in place however, when we questioned this we were informed the person did not have bed rails in situ. We saw in their daily notes some of the staff team recorded 'lifeline on bedpost'. The use of the lifeline was neither included in their risk assessment or their plan of care. We discussed these issues with the registered manager who told us this would be looked into and addressed.

Risk assessments had been reviewed depending on the severity of the risk. The higher the risk the more often these were reviewed. This meant some risk assessments were not being reviewed appropriately or in a timely manner.

There were not always enough staff to meet people's needs. Although risk assessments had been used to determine how many staff were required to support people safely, staff told us there were not always enough. For example, one member of staff informed us they had been allocated to support a person on their own: the person had been assessed as requiring two staff members. They explained, "I have been sent to do a double up on my own when we've been short staffed. I was expected to do it on my own. When I rang on-call they didn't know what to suggest. I knew another carer was around so I rang them and said if I help you with [name] will you help me, which they did."

Not everyone had received the calls they required. One member of staff said a person they had visited that morning, had not received their call the previous morning. This person required two calls a day, mainly to prompt them to take their medicines. This meant they had missed a morning call and therefore not prompted to take their medicines that morning. We shared this information with the management team for their attention and action. An investigation was carried out and a notification was submitted to CQC as required.

Whilst the management team knew their responsibilities for keeping people safe from abuse and avoidable harm it became evident that the provider's safeguarding processes had not been followed and an allegation of concern had not been followed up in a timely manner. During our inspection we were informed of a possible safeguarding incident involving one of the people using the service. We alerted the management team of this. We were informed they had also been made aware of this three days earlier however, no immediate action had been taken to report the concern to the safeguarding team or look into it. This was immediately addressed and the allegation was investigated and passed to the local safeguarding team.

People told us they felt safe with the staff team who provided their care and support. One person explained,

"It's the way the carer's really know what they are doing, it makes me have confidence in them." A relative told us, "Right from the start I have trusted the staff, they treat [person] just the way they like and I have seen first-hand just how well they all get on."

The staff team had completed training on the safeguarding of adults and knew what to do if they were concerned about someone's welfare. One explained, "I would raise anything with my manager, they all [management team] care about the people we look after, they would deal with it."

Checks had been carried out when new members of staff had been employed. This included the obtaining of references and the carrying out of a check with the Disclosure and Barring Scheme (DBS) to ensure staff were suitable to work at the service. During the interview process, standard interview questions were asked to ensure all prospective staff members were treated fairly and equally. The people using the service were protected by the pre-employment checks that were in place.

People received their care and support from staff who attended on a regular basis. One person explained, "They are regular. I can't complain about the carers being late they are never more than about five minutes and even then, they say sorry."

Where people needed support to take their medicines, staff used medicine administration records (MAR's) to record when they had administered people's medicines. People's medicine profile was included to explain to staff what people's medicines were for and the signs and symptoms to look out for should someone become unwell. The MAR charts had been regularly audited, a recent audit had identified staff had not always signed the charts when they administered people's medicines. In order to address this, the registered manager had sent out a memo to all staff reminding them of the importance of accurately completing people's MAR charts.

Staff had received training and followed the providers medicine management procedures. One explained, "We can't give medicines that aren't in a dossett box (a container used to store medicines) or prescribed by their GP."

People were protected from risks to their health and well-being by the prevention and control of infection. Staff had received appropriate training and protective personal equipment (PPE), including disposable gloves and aprons were readily available. One person told us, "It's automatic when they come, before they do anything for me hands are washed and gloves put on and when they are finished, gloves in the bin and hands washed again. It's a wonder the girl's hands don't get sore from washing them all the time."

Evidence was seen of lessons being learned when things went wrong. For example, issues had been identified with regard to staff receiving their rotas. As previously stated, the day prior to our visit a missed call had occurred because the staff member who should have carried out the call had not received their rota. Once identified, this was immediately looked into and alternative ways of sending out rotas were identified including sending them via email. We have not been able to assess the effectiveness of this practice as it had not been embedded.

## Is the service effective?

### Our findings

People's individual, diverse and cultural needs had been assessed. The protected characteristics of the Equality Act were considered to ensure people were not discriminated against because of a disability or specific care need. The registered manager explained a member of the management team completed an assessment of need prior to a person's care and support package commencing. Discussions with people using the service and records seen confirmed this.

People told us they felt the staff team were appropriately trained to meet their care and support needs. One person told us, "The girls [staff] all know what they are doing, I think they must get good training before they start work. One of the youngest carers who comes to me is one of the best, she is so gentle and caring towards me."

New staff had been provided with an induction into the service. Appropriate training had also been completed. This included training in the safe moving and handling of people, safeguarding of adults, food hygiene and infection control. Staff had also been supported to complete the Care Certificate. The Care Certificate is a national induction tool, the standards of which providers are expected to follow, to help ensure staff work to the expected requirements within the health and social care sector.

The opportunity to shadow a member of staff had been provided to enable new staff to observe the care and support people required and understand what was required of them. One explained, "I had shadowing for one evening and two full days. They said I could have more if I wanted, but I didn't."

The staff team received support through regular spot checks, supervisions, and an annual appraisal of their performance had been carried out.

People who required assistance at mealtimes told us they were supported in the way they preferred. The assistance people required was identified during the assessment process and details of people's likes and dislikes and personal preferences were included in their plan of care. For example, one person's plan of care showed they liked to have 'a cup of tea with two sugars' in the morning. Another showed they liked a 'Horlicks or hot chocolate' at bedtime. The staff team knew people's preferences. One person explained, "I don't always want what my daughter leaves me to eat so the carer always does something else for me. My daughter is ok with this, she just wants me to eat something I fancy. Whoever [staff] it is, writes in my care plan what I have had."

Staff monitored people's health and wellbeing daily and any concerns regarding people's welfare had been reported to the management team. One person explained, "I wasn't so well the other week and when [staff] came in for her first call of the day, she took one look at me and she suggested that she call the doctor as she wasn't happy with the way I looked. She let them know in the office what was going on. I was later diagnosed with a nasty chest infection."

People's care and support were provided in line with relevant legislation and guidance. The Mental Capacity

Act (MCA) 2005 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 make 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. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA. No applications had been made to the Court of Protection.

The management team understood their responsibility around the MCA. They told us if a person lacked the ability to make a decision about their care and support, a best interest decision would be made with someone who knew them well and when necessary, with the relevant professional's involvement. Not all of the staff we spoke with could remember completing training in MCA but those that did, understood its principles. One explained, "We need to make sure everything is done in their [people using the service] best interest."

We recommend all staff receive training in and are reminded of the principles of the Mental Capacity Act (MCA) 2005.

People told us permission was always obtained prior to their care and support package commencing and staff made sure they received people's consent before they supported them. A staff member explained, "I always ask before I do anything, it's only right."

## Is the service caring?

### Our findings

People told us the staff and the management team were kind and caring and treated them with respect. One person told us, "I do think the carers care about me, it's the way I am treated by them and how they speak to me when they visit." Another explained, "I have had other carers from another company before and I am much happier with how I am looked after by the ones I have now. I can't really say why but they make me feel special."

Staff had been provided with training on how to ensure people's privacy and dignity were promoted and maintained. One explained, "I always make sure the doors are shut and I cover them with a towel when providing personal care."

Staff had the information they needed to provide individualised care and support and understood the importance of respecting people's religious beliefs and their personal preferences and choices. People's preferred routines, the people who were important to them, their likes and dislikes and personal preferences were included in the documentation kept in people's homes. One support worker told us, "I always read the book and go through the care plan, it's all there."

Staff were given the time they needed to properly support the people using the service and people told us they were not rushed whilst being supported.

People explained staff encouraged them to do things for themselves which helped maintain their independence. One person said, "I can have good days and bad days and because my carers come regularly they really know when I am struggling, so on those days they help me more."

The registered manager had access to advocacy services should people need this. This meant people had access to someone who could support them and speak up on their behalf if they needed it.

A confidentiality policy was in place and the staff team understood their responsibilities for keeping people's personal information confidential. Computers which stored personal information were password protected and people's care records were kept secure. People's personal information was safely stored and held in line with the provider's confidentiality policy. The registered manager was aware of their responsibilities around the General Data Protection Regulation. This is a legal framework that sets guidelines for the collection and processing of personal information of individuals within the European Union.

## Is the service responsive?

### Our findings

People's individual, diverse and cultural care needs had been fully considered. Following an initial assessment of people's care needs, the management team had developed a plan of care which provided guidance to support workers regarding people's care preferences.

People told us they had been fully involved in the assessment process and in the development of their plan of care. One person explained, "Before I started having the carers the manager came and we did my care plan together, it is reviewed once a year."

People's plans of care included their care and support needs and how they wanted those needs to be met. They included people's personal preferences with regard to how they wanted to be supported. The plans of care checked were up to date and had been reviewed. They covered areas such as, mobility and personal care and showed the staff team how to support people in the way they preferred. The registered manager explained people's plans of care were reviewed on a three-monthly basis or sooner if changes to the person's health and welfare had been identified. Where changes in people's health had occurred, the appropriate action had been taken, including the involvement of family members and healthcare professionals where appropriate. Reviews were evident in the records checked.

People told us the staff team knew them well. One person told us, "I have never had a problem with any one not knowing what to do for me." Another explained, "I get a rota every week and I know most of the girls, but it doesn't bother me if I get girls I don't know because they all know what they are doing."

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider understood their responsibility to comply with the AIS and was able to access information regarding the service in different formats and languages to meet people's diverse needs. Support workers knew people well and knew how each person communicated.

There was a formal complaints process in place and people knew who to contact if they were unhappy or unsure about anything. One person told us, "If I need to ring the office for anything the phone is always answered and it's sorted for me." When a complaint had been received, this had been handled and investigated appropriately and in line with the provider's complaint policy.

People's requirements at the end of their life were discussed. The registered manager explained that whilst no one currently being supported required end of life care, people's individual needs would be met by appropriately trained staff with the support of the relevant healthcare professionals when the time came. An end of life care policy was in place for the staff team to follow.

## Is the service well-led?

### Our findings

There was a registered manager in place. 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.

The management team had not always followed their own safeguarding processes when a safeguarding allegation had been received. This meant people were potentially put at risk of avoidable harm or abuse.

Whilst systems were in place to monitor the quality and safety of the service, these had not identified omissions within some people's documentation.

People's risk assessment documentation was not individualised and did not always reflect people's current risks. The initial assessment in one of the records checked had not been fully completed. For example, the environment section had not been completed even though the staff were required to provide care and support in their home including, preparing meals, emptying bins and assisting them to bed.

People's plans of care had not always been signed by the person or by the person's representative. For one person whose records we checked, neither the initial assessment or plan of care had been signed to show they had been involved in or agreed to the proposed care and support to be provided.

These issues had not been identified through the auditing process. We shared this with the registered manager for their information and action.

Audits on other paperwork had been carried out. Daily records and medicine records were returned to the office on a regular basis and checked to make sure they were completed accurately and people received the care and support they required. Staff time sheets were also checked against the rota to ensure people were receiving the calls they had agreed too.

People told us the service was well managed and the registered manager and staff team were open, friendly and approachable. One explained, "I don't ring the office very often but when I have to, I am treated respectfully at all times by whoever answers. If they can, my issue is dealt with and if it is something that can't be sorted straight away, I always get a call back."

Staff members felt supported and valued by the management team. One explained, "I do feel supported, you can always talk to them." Another told us, "There is always someone available and they ring back within five minutes if they don't answer the phone."

Staff members were given the opportunity to share their thoughts on the service and be involved in how the service was run. The registered manager had an open-door policy and staff meetings were being re-introduced with a meeting booked for 21 January 2019.

People and their relatives had been given the opportunity to share their thoughts of the service being provided through regular care reviews and the use of annual surveys. The results of the latest survey sent out was being collated at the time of our visit. The registered manager explained once all the information had been analysed, a summary report would be produced and made available for people's information.

Quality assurance checks had been carried out in people's homes. This involved looking through the paperwork held and reviewing people's plans of care. People's thoughts on the support they received was also sought. A comment in one person's review stated, "I like all the girls who come to see me."

A business continuity plan was in place. This provided the management team with relevant information in the event of an untoward incident occurring and enabled them to continue to provide a consistent service.

The registered manager was aware of and understood their legal responsibility for notifying CQC of deaths, incidents and injuries that occurred for people using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events.

The registered manager was aware of their responsibility to have on display the rating from their last inspection. We saw the previous rating was displayed at the provider's office and on their website. The provider is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgments.