Care Quality Commission

Carewatch Care Services Limited

Carewatch (Lincoln)

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 caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 8 April 2015 and was announced. Carewatch (Lincoln) provides personal care in people's homes to adults of all ages with a range of health care needs. There were approximately 250 people using the service at the time of the inspection.

At the time of our inspection the service did not have a registered manager. The provider was in the process of making an application to the Care Quality Commission for a registered manager. 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 inspection on 21 July 2014, we asked the provider to take action to make improvements to their staffing levels. Following that inspection the provider sent us an action plan to tell us the improvements they were going

Summary of findings

to make. During this inspection we looked to see if these improvements had been made and found these actions had been taken and improvements to staffing numbers made.

We also asked the provider to take action to make improvements to their quality monitoring system, however the action taken has not resulted in improvements to the service which people receive. During this inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of systems in place to ensure that people received their care in a timely and consistent manner. People had raised issues about this but the provider had failed to resolve these. You can see what action we told the provider to take at the back of the full version of this report.

People said they felt safe with the care they received. Staff had completed safeguarding training and had access to guidance. They were able to recognise if people were at risk and knew what action they should take. The provider had taken action when people had been identified as at risk and learning had taken place.

People had risk assessments. Where risks had been identified there were plans to manage them effectively. Staff understood risks to people and followed guidance. Staff were alert to changes in people's usual presentation. They recorded incidents and reported them.

There was usually sufficient staff to provide people's care however the staff providing care to people was not always consistent and available when people required care. Recruitment checks ensured that people were protected from the risk of being cared for by unsuitable staff.

People's care was provided by staff who were sufficiently trained and supported. Staff undertook medicines training and had a medicines competency check. Staff had received an induction when they started employment with the provider and completed further training relevant to people's needs and were supported to undertake professional qualifications. Systems were in place to support staff and monitor their work.

Where people lacked the capacity to consent to their care relevant guidance had been followed. The provider was aware of anyone who was legally appointed to make decisions for people. People told us staff treated them with dignity and respect. People's needs in relation to nutrition and hydration were documented. People did not always receive appropriate support to ensure they received sufficient to eat at an appropriate time. Care plans were personalised and people were supported to maintain their choices. However care plans were not always consistently updated.

There had been a change in the leadership of the location in the past six months. Staff felt supported by the new leadership and the registered manager ensured people had information and support to make complaints. Where complaints were made they were investigated and actions taken in response however although individual complaints were addressed the provider did not have systems in place to learn from these or to address the underlying issues.

The majority of people told us there were good communications from the office and they knew who to speak with. People's feedback on the service was sought through telephone calls, surveys and visits. Staff were encouraged to speak with the office about any concerns they had about people's care.

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 consistently safe.

Staff understood their role in relation to safeguarding procedures.

Medicines were administered safely.

Staff were not deployed in a way to keep people safe.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People were cared for by staff who received an appropriate induction to their role.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA).

People had their health needs met. Support at mealtimes was not always provided or in a timely manner.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People were treated with dignity and respect.

Staff were aware of people's choices and care needs, however care was not always provided at a time according to people's choice.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

People were involved in planning their care however there were inconsistencies in care records.

A complaints process was in place and this was monitored however not all complaints had resulted in a change.

Requires Improvement

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

The location did not have a registered manager.

Staff felt supported and able to express their views.

Changes had not been made following comments and concerns. Systems were not in place to ensure that people received timely and consistent care.

Requires Improvement

Carewatch (Lincoln)

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 8 April 2015 and was announced. Forty eight hours' notice of the inspection was given to ensure that the people we needed to speak to were available.

The inspection team comprised of 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. The expert by experience had personal experience of community services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection the inspector spoke with four care staff and the registered manager. We reviewed records which included 20 people's care plans and three staff recruitment and records relating to the management of the service. Following the inspection we spoke with fourteen people by telephone.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in July 2014, we found there was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There were not enough qualified, skilled and experienced staff to meet people's needs. The number of staff and the way in which they were organised did not always enable visits to people's homes to be reliably completed at the right times. We asked the provider to take action to make improvements on staffing levels and this action has been completed.

There was an increase in the number of care staff and an ongoing recruitment campaign. Staff worked in teams, within each team there were senior staff to provide support and supervision to staff. However in order to ensure that people's needs were met the manager told us they had started working across teams to ensure that the staff were allocated where there was most need. Staff told us that the managers who coordinated the rotas knew the people who required care and were able to ensure that staff were allocated appropriately.

Staff said that there was usually enough time to provide care appropriately. They told us that they had 15 minutes between calls which allowed them some flexibility. However during our visit we observed people calling into the office to enquire where there care staff were because they hadn't arrived to deliver their care. People were at risk of receiving care at inappropriate times for example medicines or not receiving care at all.

Where people required two care staff to support them with their care this had been factored into the rotas. However during the inspection we heard a person who was due a call which required two care staff, contact the office because only one carer had arrived. We observed they were advised that the care could be carried out if they were happy with this. There was a risk that the person would not receive the care they were assessed as needing. The person and the staff member could have been at risk of injury.

All but one person we spoke with told us they that they felt safe with the care staff, they told us, "One carer [care staff] did not lock my key safe properly, so now I have to check every night to make sure I'm safe".

Staff told us they had access to safeguarding polices to enable them to report any safeguarding concerns. Staff were able to demonstrate an understanding of their safeguarding responsibilities.

People were kept safe as staff understood their role in relation to safeguarding procedures.

The provider had identified potential safeguarding situations and reported them to the local authority, which records confirmed.

Risks to people had been identified in relation to areas such as safety, medicines, mobility and social contact. Where risks were noted there were plans in place to manage them and maintain people's safety. For example where staff supported people with their finances, records were maintained and care plans explained the type of support and who supplied this support.

Records demonstrated the provider had a robust staff recruitment process. Staff had undergone relevant recruitment checks as part of their application and these were documented. These included the provision of suitable references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. A staff member said there were office staff who managed staff rosters and there were sufficient staff to provide people's care. They told us that the staff who managed the rotas understood the care needs of people and the geography of the area which helped to ensure people received appropriate and timely care.

From reviewing the PIR we found there had been a significant number of errors regarding medicine records in the past year. The manager told us that they had put in place checks to address the issues. We reviewed people's medicine administration records (MAR) and saw staff had signed to say what medicine had been administered. If a medicine was not administered, the reason and any action taken as result was recorded. Staff completed medicines training which records confirmed and staff had access to the provider's medicines policy.

Requires Improvement

Is the service effective?

Our findings

People told us that they thought staff were well trained. One person said, “They are all well trained and know what they are doing.” People were cared for by staff who received an appropriate induction to their role. All the staff we spoke with told us they had received an induction and they had found this useful. They said they had received training on specific issues such as catheter care and moving and handling and had opportunity to shadow established staff before they commenced fully in their role. A staff member said, “The practical element is really important.”

Staff told us they received regular three monthly office based supervision and also had spot checks carried out on their practice. They told us they found these useful and helped them to improve their practice.

People we spoke with told us that they had been involved in planning their care and felt it met their needs. However we observed occasions where people had requested their care at specific times and this had not always been provided according to their request. Records detailed what care people had agreed to, however they did not always detail what time people had requested their calls for.

When we spoke with staff they were able to tell us what they would do if people did not consent to their care and were considered at risk. Where people did not have the capacity to consent, the provider acted in accordance with the Mental Capacity Act 2005 (MCA). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity, a person making a decision on their behalf must do this in their best interests. There was evidence in the records that best interest decisions had been made for example where a person required support with food storage and disposal.

People’s care plans contained clear information about what they ate and drank, and their likes and dislikes. People had food and fluid charts in place where required. Care records also detailed what, if any support people required with their meals and when we spoke with staff they were able to tell us about the support people required. For example a person required a soft diet and this was detailed in the care records. However people told us and we observed that there were occasions when lunchtime calls were delayed which meant that people did not always receive their meals at an appropriate time.

Staff liaised with other professionals regarding people’s health needs, for example a staff member told us they had noted a change in a person’s presentation and they reported this to the office who arranged for a GP review. Another told us that they had received training from the district nurse for a person’s specific health need. Where people had specific health issues records included guidance to staff about how to monitor them and what to do if they were concerned about the person’s wellbeing. We saw advice from other professionals such as a district nurse was included in the records. Where people had specific health needs such as diabetes this was recorded in the care file.

Requires Improvement

Is the service caring?

Our findings

One person was recorded in their review as saying, "I have a positive relationship with the carers [care staff]." Another person told us, "They look after me well and I have no complaints whatsoever." They said that care staff always asked for their consent before delivering care and respected people's choices. Staff were able to tell us what they would do if people refused care. Most people said that the carer staff listened to people and responded positively to requests and their care needs. We observed staff spoke kindly and patiently with people when they called the office for clarification about their visits. Staff reassured people and if they could not answer the question directly arranged to call people back once they had the information. We heard staff call people back.

People said that care staff treated them (or their relatives) with dignity and respect and were friendly towards them. One person said, "They are very nice, and friendly," and another said, "They are lovely, very friendly and respectful". A staff member said, "I treat people as I would want a member of my family treated." They said "At the end of the day we are guests in their home and should respect this."

The manager told us staff planned care with people and focussed on the person's description of how they wanted their care provided and staff confirmed this. People's preferences about their care was recorded, for example, "Prepare a breakfast of my choice," and "I require care workers to help me prepare my own breakfast by placing utensils and crockery in an accessible place for me." We looked at the daily logs and saw that care plans were followed by staff. However we observed that care was not always provided at the times requested by people. We also observed that people were unaware of who their carers were on occasions which meant that they did not have a choice as to who delivered their care.

Staff told us that where people required a hoist to assist them with their care there were always two members of staff available to ensure that people were cared for appropriately. They said that they received appropriate training to support people to mobilise and felt confident in providing care. Records detailed what equipment was used and how to use the equipment.

Requires Improvement

Is the service responsive?

Our findings

People were aware of their care plan and told us that it was in the information which was in their home. Records showed people's care had been regularly reviewed. People were involved in the initial assessment of their needs and their care plans were updated as required with their involvement. We saw when the provider undertook reviews with people they recorded who people liked and wanted to provide their care. However, when we spoke with people the lack of consistency of care staff was raised by people and they were concerned that staff would not be aware of their needs.

When we asked staff how they knew how to care for people they told us that they read the daily notes before providing care. They said they weren't involved in the reviews of care for people but were able to feedback issues and concerns on an ongoing basis. One staff member said, "You get to know people and their needs and issues."

The provider had obtained copies of relevant assessments from other agencies when people were first referred to the service to enable them to understand the person's needs and establish if they were able to meet them. People's care records demonstrated their needs had been assessed prior to them being offered a service. Care plans when fully completed were detailed and personalised to support the person's care and treatment. For example they documented people's life experiences so that staff had an understanding of people's hobbies and interests and could chat with them about these. One record said, "I enjoy football and am a Manchester City fan."

However we found inconsistencies in the care records, for example an assessment recorded that a person didn't require assistance preparing food however the care plan said, "Care workers prepare my meals and drinks." Another person had had their visits increased but this was not clear from the record. This meant that people were at risk of receiving inappropriate care.

Staff told us that if they found people needed more time they would be able to provide this. They said that if this was a one off need they would stay with the person and provide the care and they would let the office know so that they could inform their next call. They said that if someone required additional support on a regular basis this would be discussed with managers and additional support negotiated. We heard a person contact the office and request additional care as soon as possible. The staff member responded promptly and arranged for an assessment that day so that additional care could be provided.

People were provided information about the compliments and complaints procedure, in written format and also at reviews. Records showed all written complaints had been logged, investigated and where required action had been taken, for example discussions with the person and their family and changes made to care. We saw where themes had been identified work had been carried out to address these for example the documenting of medicine administration. Three people we spoke with told us that they had raised issues and these had not been resolved. For example one person told us they had rung to complain on three occasions about the lateness of their calls and although they had received an apology the timings of calls had not improved and the complaint hadn't been addressed. A relative told us, "I have spoken to management about the carers [care staff] arriving late but they just said it was 'beyond their control'."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 21 July 2014, we found there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not have a fully effective system to regularly assess and monitor the quality of service that people received. We asked the provider to take action to make improvements and found that this action has not been completed.

Although the provider had taken action in response to our last inspection to ensure that staffing numbers increased, they did not have a system in place to ensure that visits were properly co-ordinated and that visits were timely. People had complained about the timeliness of calls but the provider had not addressed the issue. There was a lack of systems in place to ensure that people received timely and consistent care. During our inspection we heard people calling into the office for clarification of their care staff for the next few days which meant that people were not always aware of who was going to provide their care. People told us that they were concerned that staff would not know how to care for them.

We also heard people calling into the office to ask where their care staff were as they had not arrived. One person said, "It works well during the week but at weekends they have terrible time keeping. They [care staff] can arrive up to an hour and a half late and leaves [my relative] very unsafe and uncomfortable".

Another person told us, "They [care staff] arrive very late sometimes, but they do ring to let me know" and another said, "They do come late and it's always a different person". A person told us that they can sometimes wait up to three hours for their care staff in the morning, they said, "They are supposed to come at 8.00 am but sometimes it can be anytime up to 11 am". People were at risk because they were not receiving timely care, for example meals and medicines.

When we looked at three daily logs we saw times of visits varied however it was not clear what times had been agreed and therefore difficult for the provider to monitor the timeliness of visits to people. Care records did not always detail what times people required visits and the length of time of the visit. Where people had requested specific times for their visits this was not always provided. People were at risk of not receiving treatment and care in a timely manner for example their medicines which could lead to harm or deterioration in their condition.

Despite the provider putting in place some mechanisms to monitor the quality of the service such as spot checks on staff providing care and satisfaction surveys, where issues had been raised these issues had not been resolved, for example concerns about timings of visits and consistency of care workers.

There was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a change in the leadership of the location in the past six months. Staff told us they felt able to raise concerns and were confident that these would be listened and responded to appropriately. Details of the whistleblowing policy were available to staff. People were supported by staff who were encouraged to raise issues. One member of staff said, "If you have any problems you can go to the manager or coordinator." Another told us," The managers are very good," and "You're treated with respect."

The manager told us that they were currently reviewing all the care records as they were changing the style of documentation and this should be addressed as part of that review. They said a member of staff had been allocated time to carry out these reviews. The manager told us that log books were checked on a monthly basis and any errors or gaps discussed with the member of staff concerned. They said that if the concerns continued further action would be taken such as providing additional support to the member of staff.

Staff were provided with a handbook which covered the principles and values of the service. Staff told us that they had regular team meetings and felt able to raise issues at these. They said that they felt supported in their role. Where staff worked alone they were provided with equipment and support mechanisms to keep them safe.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a breach of regulation 17(1) Good Governance. Systems and processes were not in place to ensure people received appropriate care and treatment