Carewatch Care Services Limited

Carewatch (Windsor)

Inspection report

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11 January 2019

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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**

Summary of findings

Overall summary

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and specialist housing. It provides a service to older adults and younger disabled adults. At the time of our inspection the service was supporting 140 people.

At the time of the inspection, a registered manager was not registered with us to manage the service. However, we were told the member of staff currently managing the service had applied to become the registered manager and was still waiting for the outcome of their application. 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 last inspection was conducted on 13 June 2018. At that inspection, we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. To ensure people's safety and quality of care, we issued civil enforcement against the provider. Warning notices were served for safe care and treatment and good governance. We required the service to be compliant with the applicable regulation within 14 days following the warning notice.

The purpose of this inspection was to focus on the regulatory breach and enforcement we issued related to what we found at our previous inspection. This inspection looked at only two key questions; "Is the service safe?" and "Is the service well led?"

We found improvements had been made relating to good governance. However, we found people were still at risk relating to safe care and treatment. We found two people had been without their medicine for two days and the medicine charts we viewed were not always clear to identify what medicines people had received. One person's warfarin dosage was not clear and a dose had not been signed for on 7 December 2018; we could not confirm if the medicine had been given at that time. In addition, staff were required to complete the back page of medicine charts when issues occurred. For example, if someone refused their medicine or it is not available. We found back pages of the medicine charts were either missing or not completed when issues with medicines arose. We spoke with the quality officer about this and they said they would look into this. We requested further information following our inspection. We had not received this information at the time of writing this report.

We also found that one person had taken all their medicines for the entire day at once. The person self-medicates. However, we saw that they had cognitive impairment due to a brain injury. The service had not completed an incident form or reported this incident as a safeguarding concern to us or the local authority. Following this incident, we did not see a review of the person's risk assessment relating to the management

of their medicines. However, the service had arranged for a review of the person's mental health and had installed a lockable container in the person's home to lock their medicines away to reduce the risk of this happening again.

The provider was using less agency staff since our last inspection. We saw documents that confirmed a reduction in agency hours in the previous two months. This had been positive in terms of consistency with people's support and we saw less incidents were occurring. Spot checks were being carried out regularly including those of agency staff and when issues were identified, actions were in place to address this. In addition, new staff had been recruited to strengthen and improve the service. We visited six people in their homes as part of this inspection and they told us they had seen an overall improvement.

However, we saw that spot checks, telephone checks with people who used the service and agency spot checks were not audited or collated to identify trends. Managers carried out audits of documentation, including risk assessments and reviews of care. We found that these did not highlight that care plans did not always include a comprehensive life history, or detailed notes on religious or cultural needs. In addition, audits had not identified that some risk assessments required updating or reviewing to ensure people's safety.

We made recommendations relating to the quality assurance system the service currently used.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines management did not always ensure people's safety.

Risk assessments were not updated when events occurred.

Spot checks were not used as a way to identify trends. However, spot checks enabled the provider to support staff and identified further training required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Records were not always up to date to reflect people's current care needs.

Quality assurance systems were not always robust in identifying shortfalls and taking the required actions in a timely manner. Staff were more involved in the service and regular staff meetings were held to enable clear communication. □

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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 9, 10 and 11 January 2019 and was announced.

This was a focused inspection to check the service's compliance with our previously issued warning notices about safe care and treatment and good governance. The inspection team comprised of two inspectors 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.

Before the inspection we reviewed all the information we held about the service since our last inspection. For this inspection a Provider Information Return (PIR) was not requested. 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.

In order to gain further information about the service, we spoke with six people who used the service in their homes and telephoned 10 relatives and friends. We also spoke with the person managing the service, the quality officer and four care workers.

We gave the service 48 hours' notice of the inspection visit as the manager was often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we rated this key question as inadequate. Safe recruitment procedures were not always carried out. Following our inspection, we received a whistle blowing concern raised with the local authority about a member of staff not having a Disclosure and Barring Service check completed prior to them joining the service. We were aware the provider agreed to complete an investigation into the concern raised. In addition, following our previous inspection we received concerns regarding unsafe care and poor practice.

We also received information following our previous inspection relating to the competence of agency staff. In addition, specific risk assessments were not always in place. For example, people with bed rails and overhead hoists. Medicines were not always managed safely. We saw that staff had not always signed for medicines they had given and incorrect codes were used on some medicines records. People's risks from infections was compromised because staff did not follow correct procedures for infection control. We issued a warning notice and required the provider ensure compliance with the regulation. The provider has achieved partial compliance.

During this focused inspection we found some improvements had been made. Recruitment procedures were robust and less agency staff were used. Spot checks were now being carried out regularly to identify any issues or concerns about the competence of staff. Where issues were found, an action plan was in place to ensure improvements were made. Risk assessments were in place for most people. However, we saw that when issues occurred, an updated risk assessment was not always completed. For example, one person had consumed their medicines for the entire day. The person's risk assessment had not been updated to raise awareness of this and alert staff how to manage the person's medicines. In addition, an incident form was not completed following the incident and this had not been reported as a safeguarding concern to the local authority or CQC. However, the service contacted the GP for advice and had supplied a lockable cabinet to store the person's medicines. We discussed this with the quality officer, who said as they were new to the role they did not know this should have been reported.

Medicines management had improved since our last inspection. However, we found some people had been without their medicines and staff were not always signing charts to confirm what medicines had been administered.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regular spot checks of both agency staff and permanent staff enabled the service to monitor the practice of care provided. This meant that poor practice and unsafe care could be identified to ensure people were safe. However, auditing of spot checks did not take place to identify trends. Staff received training and updates on infection control. This meant that people were protected from infections.

Policies in relation to safeguarding and whistleblowing reflected local procedures and contained relevant contact information. Staff demonstrated a good understanding of the procedure in reporting abuse. Staff could contact the office or the on-call system if they wanted to discuss anything.

We asked people if they were happy with the service they told us, "Oh yes, they are very good," "Everything is satisfactory, I had people round yesterday from head office, so no need to ask me the questions again," "I have four calls a day; of course I'm [happy with the service]." One relative told us, "We don't allow men to do care for my wife. We have not asked the agency not to send men. What we do, is the man waits in the sitting room after he has helped to lift my wife up the bed. He gets the bowl of water, it works ok we are happy with that." We saw the management were committed to make further improvements to the service to ensure people received good quality care and support.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we rated this key question as requires improvement. The provider did not have robust systems to monitor the quality and safety of the service. Systems did not enable the provider to identify that safety of people using the service was compromised. Spot checks were carried out by senior staff but did not highlight the concerns we found. These included the serious issues outlined in key question safe of our prior report. Systems for identifying risks and issues were ineffective. We issued a warning notice and required the provider ensure compliance with the regulation. The provider achieved compliance with the regulation.

We found during this focused inspection improvements had been made. However, robust auditing systems of spot checks and reviews of risk assessments were not in place to ensure care provided was effective.

The service had access to care records as well as carrying out spot checks to ensure staff were competent in their role and care being delivered was of a high standard. The service engaged with people using the service on a regular basis. This could be either formal meetings, following feedback, when carrying out spot checks or during telephone contacts.

The provider had recruited a number of new staff to enable the service to improve. Less agency staff were used and this significantly reduced the issues and concerns we found during our previous inspection. When we visited people in their homes they told us the service had "Most definitely" improved.

We asked people and their relatives if they would recommend the service. One person said, "At the moment I would not recommend them. We will see how the new management go." Two other people said they would recommend the service.

Staff told us they now felt listened to by managers and office staff, who would respond promptly to any issues. One member of staff told us, "The new manager really listens to us, it's a good company to work for now." Staff told us managers positively encouraged feedback and acted on it to help improve the service. Staff meetings were held to discuss any issues or concerns. Staff told us they appreciated staff meetings recently initiated by the manager which kept them informed of changes and plans.

However, we did not see that evidence of spot checks, telephone checks with people who used the service and agency spot checks were audited or collated to identify trends. Managers had carried out audits of documentation, including risk assessments and reviews of care. However, these did not highlight that care plans did not always include a comprehensive life history, or detailed notes on religious or cultural needs. Some records required more detail, for example, for one person at risk of pressure sores the plan simply said, "encourage to stand". In addition, when events occurred we did not see an updated risk assessment to prevent recurrence of avoidable harm.

We recommend that the service follows a recognised quality assurance system, to ensure monitoring identifies any shortfalls in safety or care, and that these shortfalls are rectified in a timely manner.

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.