

Hartlepool Care Services Limited

Carewatch Redcar and Cleveland

Inspection report

17-19 Cleveland Street
Redcar
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Tel: 01642756966

Date of inspection visit:

06 January 2020

07 January 2020

09 January 2020

17 January 2020

Date of publication:

19 February 2020

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Carewatch Redcar and Cleveland is a domiciliary care service providing personal care to 83 people in their own homes.

Not everyone who used the service received personal care. 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

Medicines were not always managed safely and accurate medicines records were not kept. Although people told us they felt safe, risk assessments were not always in place. Therefore, staff did not have all the information necessary to minimise risk.

There were enough staff to meet people's needs. People told us staff were sometimes late to calls and did not always call to let them know. Staff were not always given the opportunity to meet people before attending care calls. They also did not always have all the necessary information they needed about the person in advance.

New staff were not always recruited appropriately. The provider had not always obtained a full employment history from staff before hiring them but was conducting other pre-employment checks.

The provider did not ensure care plans contained relevant information. They did not include full details of people's health needs and conditions, their preferences and views in relation to their care. This meant staff did not have access to all the information necessary to provide safe care.

The provider's quality assurance checks had not identified errors in records or missing information.

Staff had the skills and knowledge to meet people's care needs. Staff training was being reviewed and updated and a new training officer had been appointed to oversee this. Staff supervision meetings had not been happening regularly but the new management team were addressing this. Staff we spoke with felt supported.

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

The provider was not correctly recording mental capacity assessments or best interest decisions. We have made a recommendation about this.

The provider worked with other agencies to ensure they received professional advice and support when

needed. Care workers respected and promoted people's privacy and dignity. Complaints were handled appropriately.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 9 January 2019). The service remains rated requires improvement. This service has now been rated requires improvement for two consecutive inspections.

At the last inspection there were breaches of two regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of two regulations.

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement

We have identified breaches in relation to managing risk, safe management of medicines and good governance at this inspection.

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

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Carewatch Redcar and Cleveland

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 one inspector, an assistant inspector, a specialist advisor pharmacist and two Experts 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.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection and we wanted to be sure people had been told someone would be ringing to speak with them.

Inspection activity started on 6 January 2020 and ended on 17 January 2020. We visited the office location on 6 January 2020.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. 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 the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with 35 people who used the service and 11 relatives about their experience of the care provided. We spoke with 12 members of staff including the operations manager, care manager, care coordinators, care staff, training coordinator and quality officer.

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

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- The provider did not manage medicines safely. Medicines administration records (MAR) were still not being completed accurately. There were numerous signature gaps on the MAR charts and the reason for people not receiving medicines was not always recorded. Staff had amended the MAR without explanation or supporting evidence.
- The management team had not ensured staff had completed medicines records correctly. Cream application records did not guide staff where to apply creams and some did not state which cream was required.
- Staff did not have information about when to give people 'when required' medicines. They also did not record the reason for administration and the outcome.
- Staff gave some regular medicines as 'when required' medicines.

The risk of potential harm to people remained. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- The provider did not assess and manage risks effectively. Risks to people were not always being correctly assessed and some of the records that were in place did not provide staff with all the necessary information to minimise risk.
- One person, who was at very high risk of pressure damage, did not have their fluid intake or repositioning recorded which increased the risk of damage to their skin.
- Staff members were not always given essential information about new people before going out to provide care. The operations manager told us this was not always possible due to time constraints. One person said, "If there is someone new they need me to explain what to do."

The provider had failed to robustly assess and manage the risks relating to the health, safety and welfare of

people. 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 did not always follow safe recruitment practices to ensure new staff were suitable. Whilst management did some pre-employment checks, they did not investigate gaps in employment histories. The operations manager assured us they would undertake more thorough checks in the future.
- The provider ensured there were enough reliable staff to meet people's needs. One person told us, "I am getting to know them quite well. Occasionally I get a new one but they are all ok."
- Calls were not always made when staff were running late and office staff did not always call people back when they had left messages. One person told us, "Last week no one turned up so I rang the office and they said my carer had rang in sick. My point is I shouldn't need to ring them, they should ring me, this shows poor communication."

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. People felt safe and were happy with the care they received. One person told us, "Yes, I'm safe, they lock everything up when they leave. I have four calls per day and they come for the full half an hour each time."
- Staff understood safeguarding processes and knew how to raise any concerns.
- The provider had processes for investigating any safeguarding incidents and these were being correctly followed.

Preventing and controlling infection

- People were protected from the risk of infection. Staff had access to equipment to manage the risks of infection control. People we spoke with confirmed staff used this equipment appropriately. One relative said, "They seem to know what they are doing, they cream her legs, always wearing gloves or aprons when necessary."

Learning lessons when things go wrong

- The provider monitored accidents and incidents. This meant action could be taken to reduce the risk of any reoccurrence.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 consented to their care. One person told us, "[Staff] always say 'are you ok with that' before they do anything."
- The provider recorded where people had legally appointed people to make decisions on their behalf. However, we did see one document signed by a relative who was recorded as having the legal power to do so but did not.
- People's mental capacity had been considered however mental capacity assessments and best interest decisions were not being recorded. We found no evidence that people were receiving care against their wishes. The operations manager acknowledged there had been an issue with the new electronic care plans and whilst we were at the office they found how and where to record this information in the future.

We recommend the provider consults best practice guideline in relation to recording mental capacity and best interest decisions.

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

- The provider assessed people's needs before they began supporting them but these assessments were not always clearly recorded.
- People were involved in developing their support plans and risk assessments. One person told us, "Someone came out and asked what I wanted. What I needed doing."

Staff support: induction, training, skills and experience

- Staff felt supported by the management team and a programme of regular supervision meetings was in place.
- The provider delivered induction training to new staff which was in line with the Care Certificate. New staff also shadowed experienced staff to ensure they had the skills to undertake their role.
- Training was not always up to date for all staff. The service had recently appointed a training coordinator to ensure staff were brought up to date with training and to source additional training.
- People and relatives told us the staff had the skills necessary to deliver care correctly. One relative told us, "They know just what to do. They see to [family member's] catheter and they know how to do it. They are very good."

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

- Staff supported people to eat balanced meals in line with their preferences and medical requirements.
- The service did not have processes to document people's fluid intake, this meant that staff were unable to monitor the fluid intake of people at risk of dehydration. After we highlighted this the operations manager ensured they were introduced immediately.
- People gave mixed feedback on the support they received with eating and drinking. One person told us, "I'm on a special diet which my daughter arranges and they follow that to the letter." Another person told us, "Some of the Carers need more training as some can't even scramble an egg."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The service worked with agencies and healthcare professionals to ensure people received effective care. People's records contained details of support from healthcare professionals such as district nurses.
- People told us staff helped them access healthcare services when they were unwell. One person told us, "If I was to need a doctor they would get me one."

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported by a kind and caring staff team. People and their relatives spoke positively about the support people received from the staff. One person told us, "They are marvellous, they are like friends now." Another person told us, "The carers are lovely I have no complaints about them at all."
- Staff were trained in equality and diversity.

Supporting people to express their views and be involved in making decisions about their care

- People were involved in the creation of their care plans and ongoing reviews.
- People and their relatives were involved in decisions about their care. One person told us, "At the beginning I had a lot of calls, I was involved in that. Now I am better I have knocked some off."

Respecting and promoting people's privacy, dignity and independence

- People were treated them with dignity and respect. One person said, "[Staff] always knock before they come in. They always wake me up gently. They know I don't sleep very well in the night and sometimes I'm asleep when they come."
- Staff had a good understanding and were enthusiastic about promoting people to maintain their dignity. For example, they told us they ensured people were covered with towels while supporting them with personal care, ensured curtains were shut and they knocked on people's doors.
- Staff supported people in a way that encouraged them to maintain their independence as much as possible. One person told us, "I need help to sit on the chair in the shower. I wash myself and they do my hair." A relative told us, "They encourage her to stand up as she gets stiff. They encourage her but not too much."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has remained good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider was in the process of changing to an electronic care plan system. The care plans on the system were generic and there had been difficulties ensuring all necessary information was captured on this system. We discussed this with the operations manager who was going to contact the provider of the system and request some changes.
- People and their relatives took part in planning their care and had a paper copy of their care plan. One relative told us, "We had a discussion and sorted out her care plan. I think it is due a review next month."
- People and their relatives told us the care was person centred. One person told us, "They know my needs and they act on them." A relative said, "They change as [family member's] needs change and respond appropriately. They are very responsive and we feel as though we are listened to."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information was available in alternative formats for people who had communication difficulties or sensory impairment such as poor eyesight.
- Care plans did not always capture people's communication needs. We fed this back to the operations manager who said this would be improved as part of the move to electronic care plans.

Improving care quality in response to complaints or concerns

- Complaints were handled in line with the provider's policy. There had only been one complaint since our last inspection.
- People and their relatives felt they could make a complaint to the office staff. One person said, "If I had any complaints I would ring the office but I have no complaints, I'd recommend my carers they're great." A relative told us, "I don't think anyone will have any complaints if they get the same standard of care that we get."

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure a robust system was in place to monitor the quality and effectiveness of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The audits and checks being carried out had not been effective in identifying areas of concern and medicines records were still not completed correctly.
- Some care plans lacked important information and not all staff were confident in navigating the new electronic system.
- The registered manager was not involved in the day to day running of the service and did not have sufficient management oversight. At our last inspection we were told a new manager was going to register. At this inspection the provider told us the plans had changed and no further action had been taken. Following our visit the process to register a new manager was started.

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Staff were not engaged in the running of the service. Regular team meetings were not taking place and staff were only going to the office to collect rotas. The operations manager told us it had been difficult getting staff together for meetings and when they did attendance was low.
- People had opportunities to give feedback about their care and support. This included surveys and regular reviews.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People and their relatives were not always happy with the communication, particularly with office staff.
- The provider had implemented a new management structure and the office team were enthusiastic about their roles.
- Staff said the management team were approachable and supportive. One staff member said, "If you've got problems there is always the on call or the manager you can ring."

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

- The management team had a good understanding of the duty of candour. This is where we ask providers and managers to be open, honest and transparent about their service. The operations manager and care manager assisted us throughout the inspection, listened to the advice given and quickly acted upon any issues raised.
- The provider was responsive to our feedback. Following our visit to the office, the operations manager sent us evidence of the positive changes they had made and told us their plan for further actions.

Working in partnership with others

- The service worked in partnership with health and social care professionals.

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 Care and treatment was not always provided in a safe way. Medicines were not always managed safely and risks were not always correctly assessed or recorded.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to monitor the service. Complete and accurate records were not being maintained and audits had not identified areas of concern.