Carewatch Care Services Limited

Carewatch (Bristol)

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?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 24 January 2017 and was an announced inspection. This was the first inspection for the service under its current provider. The service is registered with the Care Quality Commission as 'Carewatch' but has undergone rebranding and is known to people as 'My Life Assistance'.

The service provides domiciliary care to approximately 30 people in the City of Bristol. There was no registered manager in place at the time of our inspection. However, arrangements were in place to manage the service whilst a new manager was recruited.

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.

We found that the service wasn't safe in all aspects. Risk assessments were not always completed or detailed enough to guide staff in providing safe care and support for people. We also found that systems in relation to medicines administration were not robust. We found omissions in Medicine Administration Records (MAR) and there were also practices taking place that were not in line with published guidance on medicine administration.

People reported feeling safe with the staff who attended their calls; however we found that there were shortfalls in the recruitment process that meant the service did not fully comply with the requirements of legislation. For example, gaps in employment histories were not always discussed with the candidate and in one case, photo ID had not been obtained to verify the identity of the staff member.

Staff received training and supervision to support them in their development needs. There was a standard induction programme for all staff that included topics such as safeguarding, health and safety and infection control. The programme was based on the requirement of the Care Certificate; a nationally recognised set of standards that care staff are required to meet.

Overall, people were satisfied with the care they received although some did raise issues that they felt could be improved. For example, we heard that communication could be better when staff were running late for their scheduled care appointments. People also told us they would prefer to have a rota in advance so that they knew beforehand who would be coming. This was something that the service told us they were hoping to achieve for everyone.

There were systems in place to monitor calls and ensure they weren't missed. This created an alert if staff hadn't logged in to a call with their phone and enabled staff in the office to check the situation and phone ahead to people if necessary. People told us they hadn't experienced 'missed calls' although one person did say that an evening visit running late (sometimes by 2 hours) had caused them some difficulty.

Care plans contained information about people's individual needs and preferences. Where possible, regular staff attended to people's calls so that they got to know people well. There were systems in place to monitor whether calls were taking place as scheduled.

There were systems in place to monitor the quality and safety of the service provided. This included gathering feedback from people and using this to develop a quality improvement plan.

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 safe in all aspects.

Risk assessments were not sufficient and medicines administration was not robust.

Improvements were required in the recruitment procedures to ensure they fully complied with the requirements of legislation.

Staff were trained in safeguarding vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff received training and support in order to carry out their role.

People's rights were protected in line with the Mental Capacity Act 2005.

People we spoke with met their own needs in relation to nutrition and accessing healthcare professionals. However, support was offered in these areas if required.

Is the service caring?

Requires Improvement

The service was not caring in all aspects.

Care plans were not all reviewed regularly to ensure they reflected people's current needs.

People were positive about staff and built positive relationships with them.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

There was information in people's care records that supported

staff to provide person centred care.

There were systems in place to monitor calls and ensure they happened when they should.

There was a process in place to manage complaints.

Is the service well-led?

Requires Improvement

The service was not well led in all aspects.

Breaches of regulation were found at our inspection.

Staff were positive about the current management arrangement and felt supported in their roles.

There were systems in place to monitor the quality of the service provided.

Carewatch (Bristol)

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 24 January 2017 and was an announced inspection. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that there would be someone available in the office to support our inspection.

The inspection was carried out by two inspectors. Prior to the inspection we looked at all the information available to us including the Provider Information Return (PIR). This is a form, filled in by the service to describe what they do well and any improvements they plan to make. We also looked at notifications and any other information of concern. Notifications are information about specific events which the provider is required to send to us by law.

As part of our inspection, we visited the office and made phone calls to five people who used the service and three people's relatives. We also spoke with six members of staff both office based and those providing care. We reviewed care records for four people, looked at records relating to quality monitoring and other records relating to the service such as recruitment records and complaints.

Requires Improvement

Is the service safe?

Our findings

People reported feeling safe with the staff that visited them. One person said that, "They are good. I feel really safe with them". People said that some, but not all staff showed their identification on arrival. No one expressed concern about not being shown ID and said that new staff were always introduced to them. People told us that staff were respectful of their homes and didn't go to any areas of the home uninvited.

People were not fully protected from the risks associated with their care because risk assessments were incomplete or did not contain sufficient information. In one file, risks had been identified but the section detailing the measures required to ensure the person was safe had not been completed. For example, it had been identified that there was an environmental risk in the home but no measures were in place to minimise the risk.This was rectified immediately on us identifying the issue to the service. In the three other examples we reviewed, there was a lack of detail about what staff should do to ensure the person's safety. For example in relation to one person's risk of falls, there was a measure in place that the person 'Shouldn't stand for too long'. There wasn't any detail about the length of time they could stand for. In another risk assessment, we saw that a person should be 'Supported when transferring'; no further detail was provided about what kind of support was required.

Some people received support from staff with their medicines. There was a medicines policy in place to describe the different levels of support that people required from prompting through to administering. The policy stated that Medicine Administration Records (MAR) sheets should be used when a person was being 'supported' (including prompting) or staff were administering medicines. We saw examples of completed MAR sheets that had been returned to the office, these were dated March, May and September 2016. The office was in the process of relocating so records had been packed away and it was difficult to locate more recent examples; however we found a number of omissions in the recordings on each of these charts. The manager gave potential explanations as to why there were omissions but could not be sure without looking back through the individual care records. One person who was receiving support with medicines told us that, "Some do, others don't" when we asked them whether staff recorded the administration of their medicines. Staff also told us that recording of medicines was inconsistent. One person was also being supported in a way that was contrary to current guidance in relation to medicine administration. This was because staff were administering medicines that weren't in their original packaging or a pharmacy prepared system, so staff couldn't be sure exactly what medicines they were giving. The manager made immediate changes in response to this when we fed this information back.

This was a breach of regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that improvements in medicine administration and recording had been identified in the quality improvement plan for the service. The manager told us they had identified a member of staff to review medicines for all people to ensure that information was complete and up to date.

There were processes in place to ensure that staff recruited to the service were safe and suitable for the role.

For example we saw that a Disclosure and Barring Service (DBS) check was carried out. The DBS identified people who have been barred from working with children and vulnerable adults. References had also been sought. However, in one file, we saw that the person had identified an issue on their application form that potentially raised concerns about their suitability for their role, although their DBS check had been returned and had been cleared (due to the age at which the incident occurred). We saw that the person had been asked in further detail about the issue but that no overall risk assessment had taken place. The manager told us that it was now policy for any concerns contained on the DBS check to be assessed centrally by head office and we were shown example of when this had been done. In one file we also found that there was no photographic ID as required by regulation. In two files we found that gaps in employment had not been discussed with the person concerned.

This was a breach of regulation 19 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were safeguarded from abuse because staff were trained in safeguarding vulnerable adults and felt confident and able to report any concerns. The manager kept records of any safeguarding concerns and these showed that relevant agencies had been informed. The Care Quality Commission had also been notified of safeguarding concerns as required by law.

The manager told us that there were sufficient numbers of staff to cover the care packages they had in place currently but were recruiting for further staff to enable the service to expand. We spoke with the care coordinator about the plans in place to cover staff sickness and we were told that staff covered each other where possible but if necessary office staff were able to attend calls too. Some people we spoke with had experienced office staff attending calls.

There was a contingency plan in place to manage unforeseen circumstances. This highlighted people whose visits would be prioritised in the event of an adverse event such as severe weather conditions or staff sickness. Prioritisation was based on factors such as whether the person had a relative living with them or whether they had medication that needed to be administered at a particular time. The manager also told us that within the organisation there was access to four wheel drive vehicles that could support staff to get to people's homes in severe weather conditions.

There was a system in place to record accidents and incidents that occurred in the course of delivering the service. Incidents were recorded on a computer system and staff within the organisation would analyse for any trends in the types of incidents occurring. Within the last 12 months there had only been one incident recorded for the service.

Good

Is the service effective?

Our findings

People's rights were protected in line with the Mental Capacity Act 2005. This is legislation that protects the rights of people who are unable to make decisions about their own care and treatment. At the initial assessment carried out with people, their capacity was considered and if it was found that they lacked capacity to consent to their care arrangements, a best interest decision was taken involving family members. We spoke with the manager about people who may require authorisation from the Court of Protection for a deprivation of liberty, in order to receive safe care and support. Nobody receiving care at the time of our inspection required this authorisation but the manager understood their responsibility in relation to this.

We spoke with the member of staff from the organisation who was responsible for training and inducting new staff. They told us about the four day induction that new staff would undertake. This was based on the Care Certificate. The Care Certificate is a nationally recognised set of standards that all care workers are expected to meet. The induction covered topics such as safeguarding, infection control, health and safety, food and nutrition and mental health. There was a 5th day of training completed after the probation period and this covered dementia and palliative care. Staff were offered further training for their own development needs if they wished and this included distance learning courses and other nationally recognised qualifications.

People gave positive feedback about staff training and skills although there were differences noted between new and more established staff. One relative also commented that staff skills in supporting people with dementia varied, with some staff being better able to support their relative than others. We also heard about other training needs for staff relating to the health needs of individuals which we fed back to the manager. The manager acted on this feedback immediately by informing us of the steps they had taken; including planned further training for staff. One person we spoke with told us their relative required a hoist to move and we were told us this was always done by two staff as required. They also said new staff were always shown how to use the hoist and sling.

Staff received supervision with their line manager in order to monitor their performance and discuss their development needs. This included observation of staff delivering care as well as office based discussions. The manager's records showed that supervision was not occurring as regularly as it should according to the provider's own timescales, and this was included as an action in the quality improvement plan. Even though formal supervision was not taking place according to the provider's own timescales, staff felt the current management team were approachable and the training programme met their development needs.

Within people's initial assessment, we saw that people were asked whether they required support to make contact with other healthcare professionals. The form stated that the agency would make initial contact with healthcare professionals if required; however people we spoke with did not require this kind of support.

Some people had a Health Action Plan in place. This was a new piece of documentation that the service

aimed to eventually have in place for everyone receiving support. This recorded information about any health conditions a person might have such as epilepsy or diabetes, and information about any hospital admissions the person had experienced.

People's nutritional needs were referred to in their care records. Although most people didn't require support from staff in this area, we did note comments such as, 'would like support to eat more' for staff to be aware of when providing care for the person. In some people's records we saw there was information about allergies that staff needed to be aware of.

Requires Improvement

Is the service caring?

Our findings

People were involved in planning their care through an initial meeting where their needs and wishes were discussed. This meeting took place at the person's home. The person signed a consent document to show that they agreed with what was in their care plan. It was intended that the care plan was reviewed on at least a six monthly basis or sooner if the person experienced a change in their needs.

It wasn't clear from our discussion with people whether the reviews were happening in accordance with this timescale. One person for example told us they had spoken with someone about a year ago but had nothing since. Another relative told us their spouse's planned care had not been reviewed for a few months and their views had not been sought on it for a few months, but things were "going okay". Staff also gave example of information in care plans that was out of date, suggesting that they had not been sufficiently reviewed or updated. In one case staff commented that there was information about a person's mobility resulting from an operation that had taken place approximately three years ago that was no longer relevant. Another person told us that there had been in a gap in their use of the service when they used another provider but on their return to Carewatch/My Life Assistance their care had been discussed by phone rather than a member of staff coming out to reassess their needs. This meant that staff couldn't be sure that the information contained in the person's care plan was up to date. The service had identified in their improvement plan, that care records required improvement.

People were positive about the care they received from staff. Comments included; "They always come in smiling, have a chat, and then go and say hello to my husband/spouse. They are all gentle…They're all lovely!", "They're very, very caring." And, "I only mention what I need and they do it". People felt staff saw them as individuals and respected them. For example by using their preferred form of address, and ensuring their privacy by closing curtains and doors as necessary. People told us confidentiality was maintained because staff didn't talk about other people in their presence. People said that they hadn't been asked whether they preferred a staff of a certain gender to provide their support but didn't raise any concerns in this regard.

Staff spoke positively about the support they provided; one member of staff told us about the relationships they'd built with people for whom they'd been providing care for a number of years. They told us about the 'extra' things they'd do for people such as making their bed for them if they noticed it hadn't been made yet. One person we spoke with commented, "If I've got something unusual I want them to do, they're pretty amenable".

People were given a service user guide so that they were fully aware of the services offered. The guide gave information about the contact details for the office, the range of services offered and 'what to expect' from the service. There were details given for other agencies that people needed to be aware of, including the Care Quality Commission.

Care plans identified the parts of the person's care needs that they were able to manage for themselves. This promoted their independence and supported them to maintain skills. For example, in one care file we read

about the parts of the person's personal care needs they were able to do themselves such as teeth cleaning, and other areas where they wished to have staff support.

Good

Is the service responsive?

Our findings

People felt that the service met their needs. This was largely because staff could anticipate the person's needs through knowing them or if they followed the person's wishes or instructions day to day. People could also liaise with the service if they wanted additional support or wished to cancel visits. One person commented, "They know me." They added that if they had forgotten where they had put something, staff helped them find it, and didn't make them feel stupid for not knowing where it was. However, another person commented that visit days and staff were sometimes changed which caused them anxiety and they hoped that this would soon be resolved.

We spoke with the care coordinator who was responsible for drawing up rotas. They told us that where possible, the same staff would be sent out on calls to people. This allowed staff to get to know people well and understand their needs. Staff told us that if they were going to a person who they hadn't met yet, they would phone the office to get further information about them. We were also told that at the present time, not everyone received a rota in advance so that they were fully aware which staff member would be coming. This was something that the service was planning to improve for the future. From comments we received from people, it was clear that having this information would be welcomed.

A detailed assessment was carried out with people prior to the care package starting. This covered areas of need such as their mobility, nutritional needs, hobbies and interests and emotional needs. We also saw that information was included about people's life histories; this information helped staff understand people as individuals and provide person centred care. Within the care documentation there was a description of what took place at each visit. This included details that took account of the individual ways that people wanted to be supported, for example the number of pillows they liked to have on their bed.

There were systems in place to ensure that visits took place as scheduled. The CM2000 is a system where staff phone in to log when they arrive and when they leave a call. This was being used alongside a new system where staff used their mobile phone to connect with a device in the person's home to log their visits. Staff told us that there had been some teething problems with the new system but were positive that it would work well once any issues had been resolved. These systems sent an alert to staff in the office when staff did not log in to a scheduled call. This would then allow staff to call ahead to people to warn them that staff were running late. In practice however, people told us that they did not always receive a message when staff weren't able to make the call on time. One person commented, "It would be quite nice if I knew who's coming and what time." Another person had experienced difficulties with staff arriving late for their evening call (on occasion up to two hours late) and this had been difficult for them as they had to stay up and wait which led to them becoming tired.

We asked people if they knew how to make a complaint. People told us they had not had to make any complaints, and did not know how they should make a complaint, but most felt able to ring the office if they had any concerns. One person said they would ring their social worker instead. One person commented, "They haven't treated me in any way that I need to make a complaint…not one of them!."

There was a complaints policy in place and this set out the ways in which a complaint could be raised and the timescales in which a response would be received. We saw examples of complaints that had been investigated. A response was sent to the complainant setting out the outcome of their concerns and the action taken to address any issues arising.

Not everyone was aware of the arrangement in place if they required 'support out of hours' and some expressed a wish to know what the arrangements were. One person however did say that there was an occasion when they had needed to contact someone 'out of hours' because their relative's health needs hadn't been adequately met. The member of staff hadn't been able to return, but a member of staff from the office did attend the person to address the concern. Following our inspection, the manager told us that the 'out of hours' number was the usual office number and this would be diverted to the person on call. The manager told us they would remind people of this as a result of the feedback from our inspection.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. There were temporary arrangements in place for the management of the service and the office was also being supported by staff from the wider organisation. Comments from both staff and people who used the service reflected that they felt the service was improving. One member of staff commented that, "On the whole, things were improving". However, comments also reflected that the service had experienced a difficult period recently; a member of staff said that it had been," A turbulent two years".

There were systems in place to monitor the quality of the service. We saw that feedback was gained from people by phone and through surveys being sent out. We did note that the response rate from people for surveys was low, however telephone contact with people had identified themes in the concerns that people had raised, such as carers running late and people not being informed, weekly rotas not being sent and not receiving a regular carer. This information then fed in to the quality improvement plan for the service.

We reviewed a copy of the current quality improvement plan. This showed that many of the issues we had identified at our inspection were included in the improvement plan. For example, we saw that an action had been included to revise all care plans and ensure they were detailed enough to provide person centred care. The manager also told us they had identified a member of staff to be responsible for reviewing each person's medicine regime to ensure it was up to date and reflected their current needs. We saw minutes of a meeting where this was discussed with staff. although areas for improvement had been identified, effective action had yet to be taken and breaches of regulations were found.

Staff were positive about the management arrangements in place. Staff appreciated the fact that the staff in the office would carry out care work when necessary, such as during times of staff sickness. One person using the service commented that they knew the manager as the manager had been to support them on a shopping visit. Staff also felt able to approach the current manager with any issues or concerns. One member of staff said they had recently been to the office and the manager had made time to sit with them and discuss their concerns.

There was a culture of improvement in the service. The management team were welcoming of feedback from the inspection and took immediate action where necessary to address some of the issues that we found. We were also told about ideas for the future to improve the service; this included potential improvements to the 'on call' system.

There were systems in place to ensure the requirements of relevant regulations were met. For example we saw that notifications had been sent when necessary.

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 People were not safe in all aspects of their care because risk assessments were not complete or sufficient to fully protect people The administration of medicines was not robust and did not fully protect people from unsafe practices.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures did not fully ensure that staff were safe and suitable for their role.