

Carewatch Care Services Limited

Carewatch (Heathview)

Inspection report

Heathview
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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We carried out this comprehensive inspection on 22 and 23 October 2018. This was the first inspection of the service since Carewatch (Heathview) registered with the Care Quality Commission (CQC) on 2 February 2017.

Carewatch (Heathview) provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

There are 49 apartments at Heathview, shared facilities include a bistro, well-being centre and hairdressing salon. Carewatch (Heathview) have an office based on the ground floor. At the time of the inspection we were informed that 22 people received personal care and support.

A registered manager was employed but was absent on a period of extended leave during the inspection. 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. Day to day managerial responsibilities were being overseen on an interim basis by a registered manager from another of the registered provider's locations who was generally present at Heathview for one day per week.

We identified that the registered provider was in breach of Regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to governance, records and staffing.

An internal quality audit carried out in February 2018 identified a compliance score of only 28%. A follow up review noted that compliance had increased to 78% and that the interim manager had made improvements. However, we found that the routine audit procedures were not sufficiently robust and had not identified the issues highlighted within the full version of this report.

People using the service commented about management arrangements at Heathview. Six of the people we spoke with commented that they either did not know who the manager was, they wanted to see them more often or voiced frustration that there was no-one to discuss things with as the interim manager was not present that often. The interim manager agreed that their presence only one day per week was insufficient and advised they would be liaising with their regional director with a view to increasing this.

There was a policy and procedure in place for reporting and recording accidents and incidents. However, we found shortfalls in recording procedures as records were not completed for all accidents and incidents and significant events had not been escalated to the manager. Although staff demonstrated an understanding of how to protect people from abuse, we found that improvement was needed in relation to following local

safeguarding protocols.

Staff received training and their competency to administer medicines was regularly checked. However, we found shortfalls in the completion of Medicine Administration Records (MAR) and a medicine was being administered in food without confirmation that it was safe to do so.

Most people we spoke with felt that there were insufficient staff available. Staff felt that the morning period was exceptionally busy. In addition, one person told us how they had to wait in the shower as their carers had been called away to respond to another call, leaving them waiting in the shower until the staff member returned as they were unable to get out independently. We discussed this with the interim manager who accepted there was a shortfall.

There was a business continuity policy and plan in place which contained clear steps to take in the event of disruptions to service, for example loss of significant number of staff.

Most people spoke positively about the care they received. Staff were supported to develop their skills, knowledge and competencies by completing induction and developmental training. Regular supervision and team meetings took place and staff said they felt supported by the management team.

Staff understood the need to protect people's right to privacy, dignity and independence when providing care. Staff knocked on doors, announced their arrival and sought permission before entering people's apartments.

There was a clear policy in place with regard to equality and diversity, providing guidance to staff about protected characteristics such as age, disability, religion and sexual orientation.

People's needs were assessed to ensure they could be met.

There was a policy and procedure in place to handle and respond to complaints. Although we saw that concerns raised had been dealt with, we found that they had not always been recorded.

Care records contained a good level of person-centred information which helped staff to get to know people's needs. However, we saw in one file that information was not always accurately recorded or was conflicting.

We saw that people's views about their care were regularly sought and that their choices were respected. Staff were responsive to people's health needs and contacted medical professionals or emergency services when appropriate.

The service did not provide specialist end of life care although staff received training on this subject during induction. The quality officer informed us that they were seeking additional learning in this area and following the inspection we were advised that this was available.

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 consistently safe.

Accident and incidents recording procedures were not sufficiently robust.

We found shortfalls in completion of medicine administration records and that a medicine was administered in food without confirmation that it was safe to do so.

People told us they felt there were not enough staff and that their calls had been interrupted by staff leaving to respond to other calls. The interim manager advised they felt another member of staff was required to respond to well-being calls.

Staff were aware of the procedures to follow to prevent and control the spread of infection.

Is the service effective?

Good ●

The service was effective.

Staff were supported to develop their skills, knowledge and competencies by completing induction and developmental training.

Effective working relationships had been developed with outside agencies.

Staff demonstrated a good knowledge of the requirements of the MCA and procedures they would follow.

Is the service caring?

Good ●

The service was caring.

People using the service described the staff supporting them positively.

Staff understood the need to protect people's right to privacy, dignity and independence.

People were able to express their views and choices.

There was a policy and procedure in place to ensure people were treated fairly and without discrimination.

Is the service responsive?

The service was not consistently responsive.

Complaints were not always recorded.

People's care files contained person-centred information but this was not always accurately recorded on there was conflicting information.

People were able to make choices about their care and were supported to maintain their health needs.

Social activities such as fish and chips and pie and peas nights had taken place which were enjoyed by those taking part.

Requires Improvement ●

Is the service well-led?

The service was not always consistently well-led.

There was insufficient managerial presence and/or oversight to have identified and addressed the concerns noted within this inspection.

Although there were some auditing systems in place they were not sufficiently robust.

Staff said they felt supported and that management were fair and approachable.

Regular team meetings were held giving staff an opportunity to have their say.

Requires Improvement ●

Carewatch (Heathview)

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.

The inspection was carried out on 22 and 23 October 2018 and was unannounced. On day one the inspection team consisted of one adult social care inspector, one assistant inspector and one expert-by-experience. Day two was carried out by one adult social care inspector and was announced. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we looked at any notifications received and any information we held about the provider. A notification is information about important events which the provider is required to tell us about by law. We contacted the local authority contract and quality assurance team and they shared their current knowledge of the service. The manager had not received a Provider Information Return before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. However, we gathered this information during our inspection.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with ten people who used the service. We also spoke with the interim manager, quality officer, a quality support improvement manager (QSIM) and four support staff.

We looked at care planning documentation for four people and other records associated with the operation of the service. These included three staff recruitment records; supervision and training records; accident and incident records; quality assurance audits; meeting minutes; complaint records and call schedules.

Is the service safe?

Our findings

Most people we spoke with told us that they felt the care they received was good, comments included "Very good"; "It makes me feel safe" and "Good", although one person said they felt the care was "Four out of ten".

There was a policy and procedure in place for reporting and recording incidents and accidents. However, when we looked at the accident file provided we found shortfalls in recording procedures. We found body mapping charts noting cuts and/or bruising for which there were no corresponding accident/incident forms. There was insufficient managerial oversight to have identified themes, trends or the lack of appropriate recording. The interim manager confirmed they had not carried out any analysis and, when we brought insufficient or lack of recording to their attention, was unaware of the accidents/incidents referred to.

For example, we found a body mapping chart depicting nine injuries, there were no measurements recorded on the chart. Although this is not a requirement of company policy, it is good practice to clearly detail the extent of the injuries. An entry in the daily log referred to this incident indicating that paramedics had been called due to the significant nature of the injuries and position the person had been found in. There was no accident form on file therefore, except for the information contained within the daily log, there was no evidence of investigation; outcome; actions or learning. The interim manager was unaware of this incident.

A newly introduced 'Outcome' record noted that a person was observed to have significant blackening to both arms and legs and had been admitted to hospital. The interim manager was unaware of this information and after seeking clarity from a member of staff they were informed that, although this person bruised easily, this was unusual for them. There was no evidence of an accident/incident record or body map and this "unusual", unexplained bruising had not been reported to the local authority under safeguarding procedures. However, the interim manager did so when the information was brought to their attention.

Staff were aware of the policies and procedures regarding safeguarding and told us they felt able to report any concerns should the need arise. However, improvement was needed in relation to following local safeguarding protocols.

Some people required a level of support to manage or take their medicines. We saw that staff received training and their competency was checked regularly to ensure they could administer medications safely. Medicine administration records (MAR) were used to document when medicines had been administered however we found shortfalls in completion. For example, they were not signed by the staff creating them. The interim manager informed us it was their intention for two staff to sign handwritten MAR charts, which is good practice to minimise the risk of errors. However, we were informed after the inspection that this is not company policy. Although there was a clear instruction on MAR charts of the need to record the site of transdermal applications (patch applied to the skin), this was not recorded on any of the charts we reviewed. This is important as some transdermal medicines should not be applied to the same site consecutively.

We were informed by a staff member that one person's medicine was administered in custard or rice pudding "nine times out of ten", however, there was no instruction about this on the label or the MAR chart. There was no record on file of confirmation from a pharmacist that it was safe to administer the medicine that way as some medicines are not suitable to be taken in food. We brought this to the attention of the interim manager who contacted the GP to obtain guidance.

Procedures for ordering and disposal of medicines had been recently improved with new documentation implemented. The interim manager told us that a sample of MAR charts were audited each month however, this was not documented so could not be evidenced. Their intention was to implement an audit document and a system whereby all MARs would be audited monthly however, this had not yet been put in place.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

We asked people about their experience regarding staffing levels. Most people we spoke with felt there was insufficient staff. We were told "Always running behind, especially in the day"; "Some weekends are terrible" and "Not enough carers, especially weekends, sometimes only two to three staff"; "Need more staff. They are exhausted looking after three floors" and "I think they are short of staff all the time".

When we asked staff for their views about staffing levels responses varied. Some staff felt there were sufficient staff as the quality officer would step in to cover shifts. Others expressed that mornings were exceptionally busy and there was concern about covering calls for new clients. In addition to people who received personal care calls Carewatch (Heathview) also provided "well-being" calls. Staff would respond when people pressed a pendant. Staff carried a telephone which alerted them to these calls which were in addition to their planned care calls. We observed that these calls came through frequently throughout the inspection for a variety of reasons including when people needed as required medicines.

One person told us care staff were sometimes interrupted by the telephone calls during their morning and evening care visits. They said, "The last time, when I was in the shower my carer was called away to get someone to and from the toilet, so I had to stay in the shower until (staff) came back". Some people said that their calls were delayed from time to time, between a quarter hour to an hour but that calls were not missed. One person told us they did not know what time staff would be calling "Sometimes they call early, or late, just erratic". We looked at a sample of daily logs regarding timing of calls. In those reviewed we saw that most were usually around the same time with some variation of up to half an hour. Exit times were not always recorded which meant the duration of those calls was not evidenced.

We discussed staffing levels with the interim manager who advised that there was some ongoing recruitment. However, they accepted there was a shortfall stating that an additional member of staff was needed to respond to well-being calls, however this had not been addressed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Safe recruitment checks were carried out before new staff were employed. We looked at three recruitment files and saw that application forms were completed, references obtained before the person commenced shifts and that checks were made with the Disclosure and Barring Service (DBS). This ensured they had not been barred from working in a care service. There was a robust procedure in place to review and risk assess any DBS checks that might include positive disclosures. In one of the files reviewed we saw that there was an incomplete employment history but this had not been explored or explained within the

application/interview records.

Risks to people's safety were assessed, for example falls and medication management. When a person suffered a fall a falls prevention assessment and management plan was completed. These assessments contained detailed information about contributory factors including health considerations however, there was no collated history of falls to identify frequency, triggers or high-risk periods.

There was a business continuity plan covering measures to be implemented should there be an interruption to the provision of services. This included in the event of a cyber-attack and sourcing appropriate temporary office facilities. The business continuity plan contained clear steps to be taken in relation to loss of significant numbers of support staff, co-ordinators, managers, loss of IT and data, inability to access premises and a hazard analysis table.

Staff were aware of the procedures to follow to prevent and control the spread of infection and personal protective equipment (PPE) such as gloves and aprons were used appropriately.

Is the service effective?

Our findings

Most people spoke positively about the care they received telling us "Very good care" and "Very happy with care, want to continue living here as long as I can". However, one person said "Since Carewatch took over, care has gone down the drain" whilst another described the care as "All right, mostly OK".

Staff were supported to develop their skills, knowledge and competencies by completing induction and developmental training. Staff new to the service completed an induction which consisted of classroom based training and the opportunity to spend time shadowing a support worker.

Staff received regular supervision which was "office" or "field" based. Office based sessions gave staff the opportunity to describe their experience of working for Carewatch and field based sessions assessed various aspects of their performance. There was a computerised monitoring programme using a traffic light system which flagged up when supervision was due. Staff told us they found supervision sessions useful.

Staff had access to a wide range of training. Training schedules were completed for the year and the matrix reviewed demonstrated that all current staff had completed their training with refresher sessions up to date.

Some people were supported with preparation of meals and drinks in line with their choice and preferences and a bistro area was available. The interim manager told us that they had introduced fish and chip and pie and peas nights which were very popular.

Effective working relationships had been developed with outside agencies to ensure that people's needs were met. We saw that people were supported to arrange doctors or hospital appointments and transport if needed and that staff liaised with the GP when people were unwell. Some people were supported by visiting District Nurses.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff demonstrated good knowledge of the requirements of the MCA and the procedures they would follow. A staff member explained how someone's mental capacity may fluctuate, for example when suffering from an infection and the actions they would need to take in such circumstances. We saw that staff knocked and asked if they could come in before entering people's apartments and people told us that staff sought their permission before carrying out personal care tasks.

Information from the previous shift was discussed with incoming staff, recorded in daily records and a staff communication book was used to record important information for example, about incidents during a shift

or where actions were required.

Is the service caring?

Our findings

People using the service described staff positively. Comments included: "All staff are OK. Reliable, courteous, caring and friendly, treated me well"; "Staff are all OK. Friendly" and "Staff are usually polite" although this person added that "One or two can be a bit stern at times". A relative told us "They have been so good to my (Relative). The staff are lovely to (Relative)"

We did not directly observe care delivery as part of this inspection, however people were able to tell us their views and experiences. We saw that interactions were warm and friendly and that positive relationships had been developed.

Staff understood the need to protect people's right to privacy, dignity and independence when providing care. They explained the importance of treating people with dignity and respect and described the measures that they took. For example, covering people's bodies and ensuring that doors and curtains were closed. A staff member commented "I respect what they want to wear and what they want to eat, it's up to them. Just because they are here doesn't mean they have not got a voice to say what they want"

We saw from comments recorded during quality reviews that people had been happy with the care provided. Comments included "Everybody here is very good, kind and cheerful", "They are always very helpful if I need the doctor or another professional's help".

People's right to privacy was respected. We saw that staff knocked on doors, announced their arrival and sought permission before entering people's apartments. One person told us "Staff give me privacy as needed and carers ask me what I want, always". We saw that documents were securely stored and staff were mindful of the need to maintain people's privacy. They told us they "I don't talk about residents in corridors" and that they ensured doors and curtains were closed when providing personal care.

People's religious beliefs were clearly recorded, communication needs documented including whether a translator would be needed. There was a clear policy in place with regard to equality and diversity, explaining the importance of treating people fairly, valuing differences and providing information about protected characteristics such as age, disability, religion and sexual orientation.

Is the service responsive?

Our findings

Robust individual assessments were carried out to ensure people's needs could be met which included information about people's preferred method of communication and health conditions.

There was a policy and procedure in place to handle and respond to complaints. The file provided contained records of two complaints which had been recorded and responded to in line with the provider's policy. One person told us about a complaint they had made due to the actions of a member of staff. When we spoke with the interim manager they were unaware of these issues however, on further investigation it transpired that the concerns had been dealt with and discussed with the member of staff. However, no record had been made of the complaint, actions taken or discussion with the staff member.

People's care records contained a good level of person-centred information which helped staff to get to know people's needs and staff spoken with had a clear understanding of needs.

Support files were reviewed every 12 months and were re-written if significant changes had taken place. However, in one file we looked at we saw that information was not always accurately recorded or was conflicting. For example, a significant health condition had been omitted from the new version. We brought this to the attention of the interim manager so that they could amend the records. Also, a section entitled "Communication sight and hearing" noted "Good in all three", however elsewhere in the plan it was noted that the person wore hearing aids along with the instruction "Please talk slowly and clearly, and stand near to me". The interim manager acknowledged that further improvement to support files was needed.

This was a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

There was a quality review system in place and we saw that regular reviews took place giving people opportunity to comment on the care they received. The quality review records we looked at were signed by the member of staff completing the record and indicated satisfaction with the care received. However, they were not signed by the person using the service to confirm it was an accurate reflection of their views. We would recommend that the form and process is reviewed to ensure that the person's agreement to the content is clearly evidenced.

We saw that people's choices about how they would like their care to be delivered were recorded and respected. For example, whilst some people were happy to be supported by male or female carers, others preferred female staff and therefore personal care was not provided by male staff. Support files contained a document entitled "All about me" which included detailed information about people's likes and dislikes. For example, when they would like to have a shower and what elements of personal care they would like to receive. The document also recorded things that were important to the person such as "Do not like to be rushed or having my independence taken off me".

From the documentation reviewed we saw that staff were responsive to people's health needs, contacting

medical professionals or emergency services when appropriate. A relative told us "(Relative) had (medical condition) a couple of months ago and they sent for the ambulance". Another person told us that they had been very happy with the care provided when they had needed help following some health issues.

Staff had arranged various activities such as fish and chip and pie and peas nights and a regular keep fit session was held. Recently a buffet had been arranged to celebrate the Royal Wedding. People told us that they enjoyed these activities.

The interim manager was aware of advocacy services and when they should be used. An advocate is a person who supports people who do not have friends or family to support them to ensure that their rights are protected. The interim manager informed us that they intended to display information about advocacy services to inform people of where they could find this type of support.

The service did not provide specialist end of life care although staff received training on this subject during induction and staff worked with district nurses to ensure people's needs were met. The quality officer informed us that they were seeking additional learning in this area to further improve the quality of care at end of life.

Is the service well-led?

Our findings

At the time of the inspection, although a registered manager was in post they were on an extended period of leave. During this time day to day management was covered on an interim basis by the registered manager of another of the provider's services who was present one day per week. In addition, a quality officer role had been created; responsibilities included support planning, quality, auditing and rota planning. A quality improvement manager (QSIM) from the provider's regional team also carried out service audits.

We reviewed records from the most recent Quality Service Improvement Plan (QSIP) audits and found that in February 2018 an audit was carried out at the request of senior management. This audit achieved a score of only 28% with shortfalls identified in several areas including complaints, recording and reporting of safeguarding, audits and records. An audit review carried out in June noted that improvements had been made resulting in an improved compliance score of 78%.

The interim manager had been working with the local authority to complete an action plan dated 6 April 2018 which had been reviewed during visits carried out in May, June, July and September. We could see that improvement had been achieved and, where actions had not been completed, target dates for completion had been extended.

During this inspection we asked about routine quality assurance procedures carried out by the interim manager and quality officer. The interim manager told us that a formal audit schedule was not followed but that daily logs were reviewed each month and a random sample of MARs were audited, although findings were not recorded. We were advised following the inspection that it is company policy for a formal audit schedule to be followed and for 10% of MAR charts and care notes to be audited.

Although we could see that there was some auditing carried out by the quality officer, we found that there was insufficient managerial oversight to have identified and addressed the issues noted within this report. For example, there had been no analysis of accidents/incidents carried out and the significant shortfalls regarding documentation/reporting had not been picked up although these were easily identified from the records provided. In addition, the quality officer covered care shifts which impacted upon the amount of time they were able to spend carrying out their quality role.

These issues were a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

It was clear that the interim manager had made improvements with regard to the initial concerns since they had taken over responsibility for Carewatch (Heathview), however they confirmed that their ability to sustain and make further improvements was limited due to their other responsibilities and the time they had available to spend at Heathview.

People using the service told us "I feel frustrated as there is no one to discuss things with"; "I don't know who the manager is"; "Have not seen the new manager" and "She does not come that often but I would go to her

if I have any issues". Another person told us that things had changed and although the office used to be open it was now often closed.

We discussed our findings with the interim manager and they agreed that, although they were available by telephone when not present, one day a week attending the service was inadequate to ensure quality, maintain sufficient oversight and drive further improvements. They intended to discuss this with the regional director with a view to increasing presence to two or two and a half days per week. They advised they would display a poster detailing when they would be in the building and would include their telephone number so that people would have ready access to this information. They also intended to invite people using the service to join them for a cup of tea, providing an opportunity for a chat and to build positive relationships.

Staff spoke about their work at Heathview with enthusiasm and of their aim to provide good quality care. Most staff told us that they felt supported by the interim manager and quality officer and that this had improved with the changes in management although one commented they did not feel supported and that "It can sometimes feel lonely here". Staff said that the current management team were approachable and fair, that they could make suggestions, were listened to and that working hours had taken into consideration family commitments.

Team meetings took place regularly and staff told us that they found these were useful. Comments included "Yes, they are useful, you can air your views. They keep you up to date with what's going on" and "It's the only time staff are in the building at once, everyone gets to voice their opinions all together. They make sure you feel confident enough to do so".

Meetings were also held for people who use the service and relatives. These were jointly organised between Carewatch Heathview and Plus Dane, the housing organisation. We saw that during these meetings attendees had an opportunity to discuss concerns or make suggestions to both organisations.

Although staff gave varying views about morale, some saying it was very good whilst others said it was low, all staff spoken with praised the level of team work and said it was a good place to work. The main issue affecting morale was that more staff were needed, particularly in a morning as detailed in the Effective section of this report.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered provider had not ensured that systems and processes were sufficiently established and operated effectively to adequately assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. In addition, the registered provider had failed to maintain an accurate, complete and contemporaneous record of each service user.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The registered provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were employed.</p>