

Juniper Care Limited

Caremark (Enfield)

Inspection report

1 Chase Side Crescent
Enfield
Middlesex
EN2 0JA

Tel: 02036681551

Date of inspection visit:
30 March 2016
01 April 2016

Date of publication:
18 May 2016

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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 30 March and 1 April 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service. Caremark (Enfield) provides domiciliary care and support for around 45 people in their own home. The service works primarily with older people living with dementia and people with sensory and physical impairment.

The service had recently moved location. This was the first inspection at the current address. However, the service was last inspected 8 February 2014 at the previous location and at that time was meeting all the regulations inspected. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of law; as does the provider. The registered manager was present during the inspection. The provider was also present during the inspection.

Medicines were not always accurately recorded on medicine administration (MAR) sheets. The registered manager did not complete medicines audits. Staff had received training on medicines administration and people told us that they were supported to take their medicines safely.

Risk assessments were often a tick box format and did not give staff guidance on how to mitigate risks. Risk assessments failed to provide staff with appropriate information with regards to the people they were taking care of. Risk assessments were not always updated regularly.

Care plans were not person centred and did not state people's likes, dislikes or how they wanted their care to be provided. Care plans were brief, often only several sentences and did not provide staff with an appropriate level of knowledge to be able to work with people.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm.

People were involved in decisions about their care. Where people were unable to have input, people's families were consulted. However, this was not recorded appropriately. The service did not record best interests meetings in respect of making decisions about care when people using the service were unable to do so independently. Staff had an understanding of the systems in place to protect people who could not make decisions outlined in the Mental Capacity Act 2005. However, the service worked with people living with dementia and there were no records of mental capacity assessments around decision making.

People received continuity of care. The provider always tried to ensure that the same care workers looked after people. This promoted good working relationships with people who used the service.

There was a system in place to monitor any missed visits. Missed visits were investigated and followed up.

People and relatives said that they were treated with dignity and respect. Staff were able to give examples of how they ensured that they promoted dignity. People were encouraged to be as independent as possible.

Staff received regular, effective supervision and attended monthly team meetings. Senior staff completed regular monitoring of care staff via monitoring visits.

We found that there was an open culture that encouraged staff and people to discuss issues and ideas, though team meetings and informal discussion.

There was a complaints procedure that people and relatives knew how to use.

The service operated an on-call system for any issues that arose out of hours. People and relatives told us that there was always someone available to help.

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. Risk assessments were brief and did not provide staff with guidance on how to mitigate risks.

Some people did not always receive their medicines. There were no medicines audits in place and issues around medicines were not picked up and addressed.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

There were sufficient staff to ensure people's needs were met.

Requires Improvement ●

Is the service effective?

The service was not always effective. Staff understood their responsibilities in relation to meeting the requirements of the Mental Capacity Act 2005 (MCA). However, the service did not assess people's capacity and there was no records of best interests meetings where people may have lacked capacity.

Staff had on-going training to effectively carry out their role. People were supported by staff who reviewed their working practices as they received regular supervision.

People's food and dietary needs were being met.

Requires Improvement ●

Is the service caring?

The service was caring. People were supported and staff understood people's needs.

People were treated with respect and staff maintained privacy and dignity.

People were supported to be as independent as possible.

Good ●

Is the service responsive?

The service was not always responsive. People's care was not person centred and care plans were not detailed. People's likes and dislikes were not noted. Information about changes in care

Requires Improvement ●

provided from reviews was not always actioned.

Staff were knowledgeable about individual support needs, their interests and preferences.

Complaints were responded to in an effective and timely manner. People and relatives knew how to complain.

Is the service well-led?

The service was well led. There was an open and transparent culture where good practice was identified and encouraged.

Complaints were used as a learning opportunity to improve quality of care.

Surveys were carried out to assess the standard of care provided to people

Requires Improvement 

Caremark (Enfield)

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 30 March 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by one inspector.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at seven care records and risk assessments, eight staff files, medicines records and other documented information related to the management of the service. We also spoke with three staff.

Following the inspection, we spoke with eight people who used the service, twelve people's relatives and five more staff members. Where people were unable to communicate with us, we spoke with their relatives.

Is the service safe?

Our findings

People and their relatives told us that they felt safe. One person told us, "Oh, absolutely safe. That's why I have them." Another person said, "Yes, I trust her [referring to a member of staff]." Relatives said, "Mum's very happy with them. She's very safe with them" and "Yes, I think [my relative] is very safe with Caremark."

Risk assessments were brief and did not provide staff with guidance on how to mitigate risks. Risk assessments were often a tick box format which provided little detail. Where there was information, this was often only one or two lines. For example, one person required assistance to go out in their wheelchair. A risk assessment had not been carried out and guidance had not been put in place for staff on how the person should transfer to the wheelchair safely. Staff had not been trained specifically on how to safely push the wheelchair. A further person had severely reduced mobility. The care plan noted that the person needed to be hoisted from their chair to the commode. There was no risk assessment or clear guidance on how staff should use the hoist and no risk mitigation in place.

Risk assessments were not always regularly updated. One person's risk assessment had been completed in March 2014 and a handwritten note saying 'no changes' in May 2015. Other risk assessments had not been updated or reviewed in over a year. We saw that there had been nine falls that had been documented. However, there were no specific falls risk assessments in place for people and risk assessments were not updated following falls.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were administered in people's homes and staff completed and returned Medicine Administration Record (MAR) charts to the office monthly. We looked at five MAR charts from January and February 2016. One person's MAR chart had eight omissions where medicines had not been signed for. Another person's MAR chart noted seven omissions for a topical cream. There was no explanation documented as to why these omissions had occurred.

There were no audits of medicines completed by the service. The registered manager explained that the office check log sheets that are completed by staff members following each visit and should include information around whether medicines have been given and reasons if they have not. However, MAR charts were not audited.

Care plans did not contain a list of people's medicines and what they had been prescribed for.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that staff were only allowed to administer or supervise medicines once they had completed medicines training. Training records showed that all staff had completed medicines training.

Staff were also observed in the person's home by more experienced staff before being allowed to administer medicines alone. One relative told us, "They come mainly to give medication and remind my [relative]."

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report it if they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. One staff member told us, "It's about making sure that no harm comes to them and that people are not harmed in any way." Another staff member said, "Making sure that a customer is not being abused such as physically or mentally. It can also be things like not letting them make their own decisions when they are able to." Staff told us and records confirmed that they were trained in safeguarding during their induction.

Staff understood what whistleblowing was and knew how to report concerns if necessary.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK.

We saw records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Records were detailed and noted the issue. However, there were no records of how the incident had been followed up or what the outcome was. The provider told us, "It's done but it's all done informally. It's not documented anywhere." If there was any action following an incident or accident, care plans were not updated to reflect what had happened.

The registered manager said that continuity of care was important for the people that used the service and that the service always ensured that people had regular staff that they got to know. Staff and people told us, and rotas confirmed, that people often had the same care workers visiting them, which enabled people to experience continuity of care. One person told us, "I have a regular person. If and when they can't come they always let me know but I generally have the same person." Another person said, "I have the same carer. Occasionally she goes away and they give me someone else but they always let me know." A relative told us, "We have a few [staff] that come regularly, we know them and they know [my relative]."

Staff felt that they had enough time to complete their work when they went to a call. One staff member said, "Most calls are 45 minutes to an hour. I have enough time when I go to the calls."

Is the service effective?

Our findings

People were supported by staff that were able to meet their needs. Staff told us and records confirmed, they were supported through regular supervisions. Staff told us that they received supervision every two to three months. One staff member said, "It [supervision] is about my clients, my performance and how we can improve things" Another staff member said, "It [supervision] is to see if I'm happy, any concerns, any training, if everything is ok with the customers." All staff received yearly appraisals that identified training needs and reviewed performance. Where training needs were recorded, we saw that this had been provided.

Records were kept of monitoring visits of staff. Monitoring visits looked at all aspects of how the person's care was being delivered including; medicines administration, if the person was treated with dignity and manual handling. The registered manager told us that if an issue was identified it would be addressed with the staff member in supervision. If the issue was serious then it would be addressed immediately.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

The service did not ascertain people's capacity at the point of referral. The registered manager told us that they were in the process of reviewing how they looked at people's capacity. We looked at a short mental capacity assessment form that could be used for people's decision making process. This was being introduced within the next few weeks.

One person's care plan noted that they had 'cognitive problems'. There was no detail of what the person's cognitive problems were or in what areas and how this may have affected the person. The care plan did not note if the person had difficulties making decisions and a mental capacity assessment had not been carried out. Another person's care file noted that the person was unable to sign documentation. The registered manager told us that the person was unable to sign as they were living with dementia and the person's husband signed everything. This was not documented and there were no records of best interests meeting and decisions.

A best interests meeting is when people have been deemed unable to be involved in aspects of their care and staff, healthcare professionals and relatives, make decisions on their behalf and in their best interests. The registered manager told us that family were always consulted around people's care if the person lacked capacity. However, although people and relatives told us they had been involved, there were no records to show that this had been done.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training The Mental Capacity Act 2005 (MCA). One staff member said, "As regards how much they [people] can understand. If they have capacity and what they are able to make decisions around and understanding that decision." Another staff member said, "Mental capacity is when a client cannot decide what is best for them and they need an assessment."

Staff training records showed when staff had completed training and when it needed to be renewed. All staff had received mandatory training in areas such as, manual handling, Mental Capacity Act 2005 and health and safety. The registered manager told us that new staff were beginning to work towards the new 'Care Certificate'. The Care Certificate sets out standards and competencies that health and social care workers should adhere to in their daily working life. Other staff had achieved National Vocational Qualifications (NVQ's) in health and social care.

The registered manager held a recognised training qualification, Preparing to Teach in the Life Long Learning Sector (PTLLS), and provided in-house training for staff in areas including medicines management, manual handling and safeguarding.

Staff had a comprehensive induction when they started to work to ensure that they understood people's needs prior to working alone. Induction included mandatory training such as safeguarding and manual handling. Staff were also provided with an understanding of the needs of the people they would be working with. Training was a mixture on on-line learning and classroom based teaching. New staff shadowed more experienced staff before being allowed to work on their own. On the day of our inspection there was a staff induction and we observed the registered manager training staff on providing and preparing food for people. This was done via a practical session where staff were asked how they would find out and prepare a sandwich for people and asked to demonstrate this. Staff were engaged and involved in the session and were able to explain how they would ensure choice for people around food.

Care plans showed if people required help with meal preparation when care staff visited. Some people were supported to cook meals and others required prompting to eat regularly. People that the service supported generally required light snacks to be prepared such as sandwiches, or pre-prepared meals to be heated up. Some people were supported with their food shopping. One person told us that staff, "Go out and get a few bits and bobs of food for me and bring it back. Unpack it and put it away. She always helps me make me a lovely cup of tea"

When people had specific needs, they were supported only by staff that had been trained to meet these needs. We saw that if people using the service were living with dementia, staff had received dementia care training. Where people required specific manual handling, staff assigned to the person had received manual handling training.

People and staff told us that the service did not attend healthcare appointments with people and that this was generally managed by the family. However, staff told us that if a person required support they would ensure that this was provided. Healthcare visits were documented in people's daily logs.

Is the service caring?

Our findings

People and relatives thought the service was caring. One person said, "They do more than is asked, they do little things extra." Other people said, "The carers are wonderful. They're very good and helpful" and "I find it absolutely excellent. There's nothing that's not suitable. Marvellous." Relatives said, "[My relative] gets on well with the carers and they know her well" and "It's given her confidence [having careers]. We're really thrilled." Another relative said, "They really go the extra mile for [my relative]."

People, where possible, were involved in planning their care. People told us, "Oh yes, I can tell them exactly what I want, I'm paying for a service" and "They always ask me what I want and I get it usually."

Staff told us about the importance of treating people with dignity and respect and making sure people were seen as individuals and had their needs met in a person centred way. One staff member said, "For me, it's about treating someone how you would like to be treated yourself. If I am giving personal care, I make sure doors are closed and maintain people's privacy." Another staff member said "I treat them [people] how I would want my own mother to be treated if someone was going into her. I ask, how can I assist you? I ask how they like their care to be delivered by me. I treat them with upmost respect."

Staff told us that they always tried to ensure that people were supported to do as much for themselves as possible. This was to ensure that people did not become de-skilled. One staff member said, "I promote them [people] to do as much as they can for themselves."

Staff members knew people well and were able to tell us what people liked and didn't like. One staff member told us, "You get to know people, what they like and don't. I have one lady who likes her table laid and I try to make it so it looks nice. I always ask and most people are able to tell me exactly what they want."

Care plans included information on people's religious observance. However, this was not always documented in detail in the care plans. Staff members were aware of people's religious needs. One staff member told us, "If the person has a religion we support them." Where possible, staff were matched to people according to their preferences.

We asked staff how they would work with lesbian, gay, bisexual and transgendered people. One staff member told us, "I don't see it as a problem, I would treat them the same as everyone else." Another staff member said, "It's all about the best care. I wouldn't have a problem. Staff were positive about working with lesbian, gay, bisexual and transgendered people."

Is the service responsive?

Our findings

Care plans were not person centred and did not include details of people's likes and dislikes. Information contained within care plans was often very brief, consisting of only a few lines. Information from people's initial needs assessments that were completed and detailed at the point of referral had not always been transferred into the care plan.

One person's care plan was three lines long and the person received a three hour visit. There was very little information around what the staff should do during the visit. Care plans were task focused and not detailed. Another care plan noted that two people being supported had a specific faith and requirements. There was no information in the care plan around how this would be achieved or how staff should support the individuals to maintain their religious observance. On speaking with staff, they knew people that they worked with well and were able to explain the tasks that they performed and how people wanted to receive their care.

Another person's care plan noted that they wanted time with staff to practice reading. There was no further information as to how staff would provide this support, what type of support the person required and why the person requested this. It was also unclear if this had been happening.

Reviews of people's care were carried out every three months with people and their family members, where appropriate. One person told us, "Yes, they do reviews of my care, I am involved." However, results of reviews were not always actioned. We saw that one person had requested to have their hair washed each week and stated that their bedding was not changed regularly during a review in January 2016. There was no information as to if this had been happening and the care plan had not been updated. The provider contacted staff to find out if this had been happening whilst we were there. The person had not been having their hair washed as there was not enough time during the call. The provider said that this would be addressed. However, the person had identified in their initial assessment that they wanted staff to help them wash their hair.

Another person asked that breakfast was prepared later in the call as it went cold whilst carers were completing other tasks with them. However, the review form stated 'no changes' and the care plan had not been updated. We spoke with the provider about this who told us that this had been changed and the breakfast was being prepared later. However, this had not been documented anywhere and the review form should have noted changes.

Care plans were not person centred and did not provide enough information and guidance for staff to ensure that people received care and support in a way that they wanted to.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service completed quality assurance spot checks every three months. These looked at overall care

provided. We saw that one person's family requested that call lengths were increased in the morning to provide extra care. This had been actioned by the registered manager.

The service provided, where identified, support with medicines, personal care, light meal preparation and household work such as cleaning and ironing. People and relatives told us that they thought the service met their needs. One relative said, "They know exactly what my relative likes as they've been with her a while. The carers know what her needs are." People's needs were assessed when they were referred to the service. A tailored package of care was devised according to the outcome of the assessment. People's initial assessment included physical care needs, practical needs such as, washing and meal preparation and overall wellbeing.

There had been no missed visits in the last six months. The registered manager told us that any missed visits were taken seriously and investigated. A weekly audit was completed by the registered manager to ensure that no visits had been missed. Log sheets were also audited on a regular basis. Log sheets are daily records that are kept at people's homes and completed by staff. Staff documented what time they arrived and left log sheets were returned to the office every month. The service did not have an electronic monitoring system to check staff arrival and departure times. However, the registered manager told us that the office had a "lot of contact with people and their families and they call us if a carer does not arrive." A relative said, "Yes, they're [staff] on time. If they're not going to be on time, they call and let [my relative] know."

We asked relatives and people if staff stayed for the correct amount of time that had been agreed at the assessment stage. People said, "Yes, they always stay the right time" and "They stay for as long as they're supposed to. If they finish early they stay and have a little chat." Relatives told us, "They stay for the full amount of time and if they finish they stay and chat with [my relative]." A staff member said, "I always stay the right amount of time, sometimes a little more because I always finish up my visit with a cup of tea and a chat."

The service had a complaints policy. The complaints policy was given to people when they began using the service. The registered manager told us that, where family members had been involved, they were also given a copy of the complaints procedure. People and relatives told us that they knew how to complain. One person said, "Yes, they've given me a number but I have nothing to complain about." A relative told us, "Yes, there is a system and I know how to complain if I needed to." Another relative said, "I'd phone through to the office but I've never had to complain."

Is the service well-led?

Our findings

Staff said that the registered manager promoted an open and inclusive environment. One staff member said, "He's lovely, very warm and caring. He gets things done and will go out of his way to help you." Another staff member said, "He's [the registered manager] a great care manager, he really is. He does the best for us and the customers. He shows us appreciation and is competent at his job." A relative said, "The office and the manager are very approachable. Very friendly. Whenever we raise anything, they take it on board."

Each week the registered manager produced a newsletter for staff called, 'Please Read Me'. This included anything the registered manager felt the staff should know and acted as an information sharing resource. We saw that one issue had information around the mental capacity act and legislation. Others reminded staff of daylight savings, staff cover over bank holiday periods and any changes within the company. Staff that we spoke with felt that the newsletter was helpful in connecting staff as generally they work alone.

The registered manager told us that he tried to make the office as welcoming as possible when staff and relatives came in. We observed staff dropping off their time sheets or collecting equipment stayed for coffee and cakes, provided by the office. There was good communication and rapport between staff and management.

The provider operated on on-call system for out of hour's issues that arose. This operates seven days a week between 17:30 and 09:00 and at weekends. Relatives told us that they could always contact staff in the office and someone was available when the office was closed.

The service completed annual customer surveys. We saw the most recent surveys from November 2015. Overall, feedback was positive and people and relatives were pleased with the care that they were receiving. Results from the surveys had been shared with staff, in team meetings and with people the service supported.

The registered manager completed audits around missed calls. However, the service did not complete any audits around people's care plans or risk assessments. The registered manager failed to pick up that some risk assessments had not been reviewed for over a year.

Regular team meetings were held. Staff told us that they felt they could raise any issues and that the registered manager would listen to them. One staff member said, "We have regular team meetings. It is very open and they [the management] make it comfortable to voice your concerns." The registered manager had got a speaker in from Dementia Friends to do a presentation around working with people living with dementia at the team meeting. Staff were provided with a copy of the information to improve knowledge.

Whilst comments about the registered manager were positive, we found failings in information documented on care plans and risk assessments. Care was not person centred and risk assessments did not provide guidance for staff to be able to mitigate risks. People's capacity had not been documented or assessed and there were no records of best interests meetings. There were no medicines audits and issues around

medicines were not picked up and addressed.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that planned care was appropriate, met people's needs and reflected their preferences. Regulation 9(1)(a)(b)(c) 3(a)(b)(c)(d)
Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that care and treatment of service users was only provided with the consent of the relevant person Regulation 11(1)
Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not adequately assess the risks of service users receiving care and treatment Regulation 12(1)(2)(a)(b) The provider failed to ensure safe management of medicines Regulation 12(2)(g)