CSN Care Group Limited

Carewatch (Isle of Wight)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Carewatch (Isle of Wight) is a domiciliary care agency which provides support and personal care to people living in their own home. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection 74 people were receiving a regulated activity.

People's experience of using this service and what we found
Although people that received care from Carewatch (Isle of Wight) were generally happy with the care they received we found shortfalls in the safety and management of the service which placed people at risk of harm.

The provider's quality assurance processes were not effective and had failed to identify concerns we found and improve the quality and safety of the services provided.

Not all risks for people had been fully assessed and plans put in place to mitigate those risks as far as possible. Where risk assessments were in place a lack of staff meant that they were not always followed. Medicines had not always been managed safely.

Recruitment procedures were not always effectively followed to ensure only suitable staff were employed and we have made a recommendation to support improvement.

People told us they felt safe when receiving a care service and staff and the manager were aware of their safeguarding responsibilities.

Staff told us they always had enough Personal Protective Equipment (PPE) and had not experienced a shortage during the COVID-19 pandemic. They described how and when they would use PPE which reflected appropriate current guidance. Care staff told us they were regularly testing for COVID -19. The manager said they were now seeking evidence from staff to confirm completion of testing and test results.

People and their family members were all positive about the caring nature of the staff. People told us they were always treated with dignity and respect. People felt able to express their views and request additional tasks if required.

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

Rating at last inspection and update
The last rating for this service was good (published 11 May 2021).

Why we inspected

The inspection was prompted in part due to concerns received about risk management and staffing levels. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. During the inspection we identified that the existing rating for caring was no longer correct and we therefore expanded the inspection to also cover this key question.

For those key questions not inspected, (effective and responsive) we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, caring and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Carewatch (Isle of Wight) on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk assessment, medicines management and ensuring the quality of the service at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Carewatch (Isle of Wight)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

This was a focused inspection to check on a concern we had about risk management and staffing levels.

Inspection team
The inspection was completed by two adult social care inspectors and an Expert by Experience who made phone calls to people using the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. The provider was recruiting to the registered manager role. There was an acting manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 8 April 2022 and ended on 22 April 2022. We visited the agency office on 8 April

2022.

What we did before the inspection
We reviewed information we had received about the service since they were registered, including notifications. Notifications are information about specific important events the service is legally required to send to us. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all this information to plan our inspection.

During the inspection
We spoke with six people who use the service and three people's family members and sought feedback from the local authority and professionals who work with the service. We spoke with six care staff members, the manager and four office staff members. We also spoke with the provider's nominated individual and the provider's area manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records, including four people's care records and medication records. We looked at four staff files in relation to recruitment and records relating to staff training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Not all risks for people had been fully assessed. For example, one person's assessment identified risks relating to choking, blood thinning medicines and risk of skin damage for which no individual risk assessments were in place. Similar issues were identified within the other care files viewed. Three care staff said they were unsure about risk assessments and others confirmed that these were not always in place. The failure to formally assess all risks meant that some preventative measures may not be put in place meaning people were at increased risk of harm.

● Staff told us that they have had to undertake some personal care tasks which they had not received training to complete. Not having the information or skills to undertake specific personal care tasks places the person at risk that the task will not be completed safely.

● The provider told us reviews of care plans and risk assessments were an ongoing process and that these were updated to reflect any changes in the person's needs or risks. However, when reviewing the electronic records which care staff worked from, we found not all risks had been identified and for others assessment and mitigation measures were not in place. This meant that reviews of care plans and risk assessments had not been sufficiently robust to ensure people's safety.

The provider had failed to effectively assess and keep under review the risks to health and safety of service users. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Where we identified missing risk assessments, the manager took prompt action to put these in place.

● People's home and environmental risk assessments had been completed by the management team to promote the safety of both people and staff. These considered the immediate living environment of the person, including lighting, the condition of property, pets and security.

● Business continuity plans were in place to ensure that individuals were prioritised in terms of risk during crisis situations.

Using medicines safely

● Care plans included information about the support people required with their medicines. When this required staff to administer medicines it was noted as a task for care staff to complete.

● Where staff needed to apply topical creams there was inconsistent information within care plans as to which topical creams should be applied.

● People also said they had their medicines correctly and on time. One person said, "They [care staff] wait with me whilst I take it." Another person told us, "They help with it and remind me at night to make sure that

I have taken a small pill." One person told us, "Yes they put cream on my legs and are respectful in doing so."
● People's care records included specific information about the level of support people required with their medicines; lists of people's prescribed medicines, including possible side effects and information about who was responsible for ordering medicines.
● Staff had been trained to administer medicines and had been assessed as competent to do so safely. This was reassessed yearly or following any medicines errors.

Staffing and recruitment
● The provider's recruitment procedures were not always effectively followed to ensure only suitable staff were employed. We reviewed four recruitment records which showed some information was missing and pre employment checks had not been fully completed before staff worked with vulnerable people. This included full employment history, interview record and satisfactory conduct evidence from current or relevant previous employers.
● The provider had not ensured staff responsible for recruitment had a clear understanding of what was necessary to ensure all appropriate recruitment checks were being undertaken.
● We discussed this with the provider and manager who undertook to ensure office staff fully understood the processes needed to ensure all pre employment checks would be fully completed in the future.

We recommend the provider undertakes a full audit of all employment records and where gaps are identified missing information is sought.

● The service had experienced problems providing enough staff to cover all care visits meaning that on some occasions two staff had not been provided where necessary. Where this had occurred, minimal care had been provided. For example, daily notes reviewed showed that on some occasions people were cared for in bed as enough staff were not available to safely use moving and handling equipment.
● Staff had not always followed people's care plans meaning that tasks to reduce risks were not always completed. For example, one person's care plan stated that they should have their hair washed on a specific day each week. Records of the care provided showed that this was not happening with care staff stating they had not washed the person's hair as they did not have time. The records also showed that staff had left the care call approximately 15 minutes early meaning there should have been time to complete all tasks. We identified a similar issue with hair washing in another person's care records. Whilst people had been involved in decisions about their care planning the failure of care staff to follow care plans, meant people were being placed at risk as all required care was not being provided. The manager said they had identified this issue and taken action to address this with care staff. They assured us people now had their hair washed as per their care plans.
● Some care staff said they did not always have time to read care plans and relied on checking the previous care notes and tasks to know what was required. This meant people may not receive all the care they required as previous staff may not have fully completed all tasks.
● Out of office hours, a senior staff member was on call to support care staff should the need arise.
● Some people confirmed they had a regular team of care staff. For example, one person said, "Yes [same care staff] they are on time and usually stay the allocated time." Other people were less positive and said, "Sometimes, it varies", and "We don't know what time they are coming as we don't get a rota."
● The lack of sufficient staff to meet everyone's care packages were in part caused by a clause within the provider's contract with the local authority which compelled the agency to accept new referrals even when they knew they did not have sufficient staff to meet the increase in demand. This clause had been temporarily suspended and the staff member responsible for allocation of care staff said the service now had enough staff to meet the current care needs of people they were supporting.

Systems and processes to safeguard people from the risk of abuse

● Appropriate systems were not always followed to protect people from the risk of abuse. This included the failure to ensure all risk assessments and recruitment checks were completed.

● People told us they felt safe. For example, one family member said, "Yes, we feel safe when the carers come." A person told us, "Yes I feel safe, they are also caring."

● Some staff knew what action they should take if they suspected a person was at risk of abuse. One staff member said, "I would tell [manager] immediately if I had any [safeguarding] concerns, but I also know I can go to the [local authority] safeguarding team." However, some other care staff were unsure about safeguarding and who outside the provider they could report concerns to. This meant, should the manager or provider fail to take appropriate action, people would remain at risk as staff would not know what they could to ensure people's safety.

● The manager was clear about their safeguarding responsibilities. They said they understood who they could contact at the local authority safeguarding team if they wished to discuss any concerns. Staff had access to a 'Safecall' system meaning they could forward any safeguarding concerns to the providers' responsible person for investigation.

Preventing and controlling infection

● Suitable policies and procedures were in place for infection prevention and control.

● Staff told us they had completed relevant infection and prevention training including food hygiene training during their induction.

● Staff told us they always had enough Personal Protective Equipment (PPE) and had not experienced a shortage during the COVID-19 pandemic. They described how and when they would use PPE which reflected appropriate current guidance. Care staff told us they were regularly testing for COVID -19. The manager said they were now seeking evidence from staff to confirm completion of testing and test results.

● People or family members did not raise any concerns in respect of prevention and control of infection. One person said, "They wear all the PPE." A family member commented, "They have been good at wearing all that stuff".

Learning lessons when things go wrong

● Where an incident or accident had occurred, the provider had procedures in place to investigate the cause, learn lessons and take remedial action to prevent a recurrence.

Good

Is the service caring?

Our findings

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

At our last inspection we rated this key question Outstanding. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- A person told us, "I feel safe, but I prefer women [care staff]." Another person told us they had made a complaint after male staff had been allocated when they had said they preferred a female care staff member.
- Daily notes included comments by care staff to show where staff had offered choices to people and where people's preferences such as for meals or not receive some aspects of their care had been met. People confirmed they were offered choices. One person said, "If I ask, they [care staff] bath me, they always oblige". Another person said, "They [care staff] are very personable, and they ask permission."
- People felt able to express their views and request additional tasks if required. A person told us, "They [care staff] always ask if I need something before they leave."

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

- People and relatives told us that staff were kind and caring. One family member said, "They are lovely, and he enjoys them coming." A person told us, "Yes, they [care staff] are very kind".
- Staff had built up positive relationships with people. Staff spoke about their work and about people warmly. Most care staff told us they had a regular rota meaning they generally visited the same people and had therefore had the opportunity to get to know people and people had the chance to get to know them.

Respecting and promoting people's privacy, dignity and independence

- People told us they were treated with dignity and respect. One family member said, "They [care staff] make a point of closing door, yes very mindful, they would not dream of leaving the door open when he is dressing." A person told us, "Yes they [care staff] are certainly respectful".
- Staff explained how they respected people's privacy and dignity, particularly when supporting them with personal care by, for example, ensuring doors were closed and people were covered up. Care plans guided staff to ensure privacy and dignity were maintained during the provision of personal care.
- People confirmed they were encouraged to be as independent as possible. One family member said, "They [care staff] are good as they let him do what he can."
- Care staff had access to information about the level of support each person required and what each person could do for themselves. Although some staff told us they did not always have time to read care plans, daily records of care demonstrated that people were supported to be independent.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. and did not always support the delivery of high-quality, person-centred care.

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

- The provider's quality assurance processes were not effective. During the inspection we identified areas which required improvement which are detailed in previous sections of this report.
- The manager confirmed that there had been limited formal quality monitoring of the service which, if in place, would have identified the issues we found during this inspection. The manager had a service development plan. This did identify some of the concerns we found during the inspection however, action to address these issues had not been completed.
- The manager was supported by an area manager and quality officers and staff within the office. The quality officers' roles were to complete assessments and reviews as well as undertaking field supervisions of care staff. We were told this had not always been possible to achieve as the quality officers had been required to undertake care shifts. However, following recruitment and a change in the providers contract with the local authority, we were told quality officers were now able to focus on their roles.

The provider has failed to ensure systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Where we identified improvements, such as the need to improve recruitment records, risk assessments and care planning documentation, the manager took prompt action and committed to making further improvements.
- The manager was committed to ensuring that all necessary action was taken to address the areas for improvement we identified during the inspection to ensure people received the service they needed. They told us they were getting support from the provider's senior management team and were due to commence training to help them fully understand and fulfil their role.
- The service did not have a registered manager at the time of the inspection. The previous registered manager had left the company in September 2021. A manager had been appointed however they had a period of extended sick leave shortly after commencing their role and failed to apply to become registered manager. The provider was now recruiting a new registered manager at the time of the inspection.
- Providers are required to notify CQC of all significant events. Whilst we had been notified about some incidents, we identified a safeguarding concern which we had not been notified about. The manager said they had previously been unsure about the requirement for notifications however they were now fully aware of what they formally needed to notify CQC about.

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

● In October 2021 the provider had sent surveys to people and staff to assess their satisfaction with the service. We were provided with a summary of the responses. This showed areas where improvements were required. The manager was unable to say what action had been taken in response to the issues identified in the surveys.

● Some formal reviews of care were completed with people or their family members. However, we saw within some reviews that action was not always taken when people expressed concerns with the care or care staff. For example, one review noted a person had said that there was 'no point having a schedule as it was never kept to' and 'carers did not arrive on time or stay the full length of time'. The manager was unable to say what action had been taken following this review and none was recorded on the review form.

The provider has failed to act on people's views about their care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Protected characteristics, including sexuality, religion, race and disability, were respected and supported. This information was included within a personal history form in place for each person. This included information about people's life histories which would help staff when initiating conversations and to understand more about what was important for each person.

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

● People and family members told us they felt able to raise issues or make a complaint. One family member said, "I would always raise issues". Whilst a person told us, "They [management team] deal with things in a nice way". We were provided with examples of when people had raised concerns and appropriate action to the satisfaction of the person had been taken.

● People and staff were very positive about the support they received from the manager and felt they could go to them with any issues or concerns. One staff member said, "She's [manager] always available, I can contact her at any time, and she is really supportive." Another staff member described the response they had received when they had requested a reduction in working hours and this had been resolved completely to their satisfaction. A person commented, "The manager changed recently; she seems ok".

● The manager had a clear vision for the service. They said, "I know there are things we need to improve on but I want Carewatch to be an outstanding service." They identified a key barrier was the recruitment of high-quality staff and were looking at new ways of recruiting staff who may not have considered care as a career option. They were due to speak at a local college careers event to promote adult social care careers.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had a duty of candour policy that required staff and management team to act in an open and transparent way when accidents occurred. The provider and manager understood their responsibilities in relation to the duty of candour.

Working in partnership with others

● The service worked well and in collaboration with all relevant agencies, including health and social care professionals. The manager was aware of who they should contact when required for a variety of needs. They described joining various local meetings to discuss issues within the provision of community-based support services. This helped to ensure there was joined-up care provision.

● The computerised care planning system included an option for other health professionals, such as

paramedics, to access the care and medication records should the need arise. This would mean they could understand what medicines were prescribed and had been administered or what the person's previous medical history included. This would help ensure people received appropriate care in emergency situations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to ensure people received safe care. People were at risk of unsafe care as risk assessments had not always been completed or kept under regular review. Regulation 12(2)(b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to ensure systems and processes to assess, monitor and improve the quality and safety of the service are effective or act on people's views about their care. Regulation 17 (1)(2)(a)