County Care Services Limited

Carewatch (South Cumbria)

Inspection report

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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

Overall summary

This announced inspection took place on 5 December 2014 and 6 February 2015. We last inspected this service in December 2013. At that inspection we found that the provider was meeting all of the regulations that we assessed.

Carewatch (South Cumbria) is a domiciliary care agency based in Kendal. The agency provides personal care and support to people who live in the south of Cumbria. It provides care to people in their own homes, including people who need support due to physical needs, mental health needs, people who live with dementia and people who have a learning disability. There were 70 people receiving support from the service when we carried out our inspection.

There was no registered manager at the service. 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.

People were not safe using this service because risks were not managed effectively. Some risk assessments

Summary of findings

were not fully completed and others held inaccurate information. This meant that the care staff did not have accurate information about how to protect people from harm.

The service was not well managed and the systems used to assess the quality of the service were not effective. Although the provider had carried out their own checks on the service and had identified areas which required improvement, action had not been taken to address the issues found.

People could not be confident that their rights were protected because the Mental Capacity Act 2005 Code of practice had not been followed when people were not able to make their own decisions about their care. The provider did not have robust systems in place to ensure that decisions about people's care were made by those who had the legal right to do so or that they were made in the individual's best interests.

Care records were not always completed fully and did not include guidance for staff on how to support people who had complex needs. This meant people did not always receive the support they required.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the rights of people living with dementia not being protected, care not being planned and delivered to ensure people received the support they needed and not monitoring the quality of service well enough. These corresponded to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found a breach of the Care Quality Commission (Registration) Regulations 2009 because the provider did not have a registered manager in place at the service.

You can see what action we told the provider to take at the back of the full version of the report.

People received care from a small group of staff who they knew and who helped them to remain safe in their homes. Checks were carried out on new staff to ensure they were safe and suitable to work in people's homes.

The care staff treated people with kindness and respect. People valued the relationships that they had with the staff who supported them.

People were asked for their views about the service. The provider had formal and informal systems to gather the views of people who used the service.

People knew how they could complain about the service they received and were confident that action would be taken in response to any concerns they raised.

Summary of findings

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 safe.

People were placed at risk because the care staff did not have accurate information about how to protect people from harm.

People received care from a small group of staff who they knew and who helped them to remain safe in their homes.

The provider carried out checks on new staff to ensure they were suitable to work in people's homes.

Requires Improvement

Is the service effective?
The service was not effective.

The Mental Capacity Act 2005 Code of practice had not been followed when people were not able to make their own decisions about their care. People could not be confident that their rights would be protected if they were not able to make decisions about their own care.

People received the support they needed to prepare their meals.

Staff were trained to provide the support people required.

Requires Improvement

Is the service caring?
The service was caring.

Staff were kind to people and treated them with respect.

The staff took appropriate action to protect people's dignity and privacy.

People were included in decisions about their care and were supported to maintain their independence.

Good

Is the service responsive?
The service was not responsive.

People did not always receive the support they needed because staff did not have accurate and detailed information about how to assist them.

The provider had systems for receiving and handling complaints. People knew how they could raise concerns about the service and were confident these would be acted on.

Requires Improvement

Is the service well-led?
The service was not well-led.

There had been no registered manager in post for over twelve months.

Requires Improvement

Summary of findings

Although the provider had carried out checks on the service, prompt action had not been taken to address areas which required improvement.

The provider had formal and informal systems to gather the views of people who used the service. People were asked for their views about the service and action was taken in response to their feedback.

Carewatch (South Cumbria)

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 took place between 5 December 2014 and 6 February 2015 and was announced.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was carried out by an Adult Social Care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspector visited the agency office on 5 December 2014 and 6 February 2015 and looked at care records for 6 people who used the service, training records for 5 staff and recruitment records for 2 staff. We also looked at records relating to complaints were managed and how the provider checked the quality of the service provided. We spoke with fifteen people who use the service and 4 relatives on the telephone and visited 3 people in their own homes. We also spoke with the manager of the service and 6 care staff.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, including the information in the PIR, before we visited the service. We also contacted the local authority commissioning and social work teams for their views of the service.

Requires Improvement

Is the service safe?

Our findings

People were not safe using this service because risks had not been managed effectively. We found that some risk assessments were not fully completed and others held inaccurate information.

One person's care assessment, completed by their social worker, identified that there was a hazard to their safety due to a "high risk of falls". The assessment also showed that this person smoked tobacco. However, the risk assessments completed by the service stated that they were not at risk of falling and that there was no risk from them or other people smoking in their home. There was no information for staff about how to protect the person from the hazards that had been identified in their care assessment.

The risk assessment the service carried out for another person contained inaccurate information and had not been fully completed. This person required support in their home because they were recovering from a serious injury which had been caused by them falling over. However the risk assessment stated that they were not at risk of injury from falling. Other areas in the risk assessment had not been completed. For example, the risk assessment identified that there were hazards related to the person's general or physical health and around access to their home. There was no information about what these hazards were or how they were to be managed. This meant the care staff did not have information about how to protect the person.

We found that the registered person had not ensured that risks to people's safety were managed and people were not protected from the risk of harm. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe with the staff who visited them. One person told us, "I feel very secure" and another person said, "I feel totally safe with the staff who come to me". A relative we spoke with told us, "I am confident with the service, I know [my relation] will be safe".

People told us that they usually received support from a small team of care staff who they knew. They said they received a copy of their care rota, so that they knew the care staff who would be coming to their home for each visit. This helped to keep them safe.

People told us that the care staff helped them to keep their homes secure to ensure their safety. One person told us, "The staff remind me to lock my door when they go and not to answer it to anyone else". Another person said, "The staff lock my doors for me".

Everyone we spoke with told us that there were enough staff to provide the care they required. However two people said that there were times when they felt the staff who visited them "rushed" their care. One person said, "They [care staff] sometimes rush because of getting to the next visit". Another person told us, "The staff are a bit rushed and never have any time". Other people told us that the staff who visited them did have enough time to spend with them and provided their care in a patient and unhurried way.

All the staff we spoke with told us that they had completed training in how to identify that a person may be being abused. They showed that they understood their responsibility to report any concerns immediately to ensure that action could be taken if required to protect the individual. One staff member said, "I know I may be the only person they [people using the service] see, if I thought something 'wasn't right' I'd have to report it, some of the people we support are very vulnerable".

People told us that the staff allowed them to make choices about their care and to maintain control of their lives. One person said, "The staff give me advice about staying safe, but they know it's my life and my choices, they don't try to 'take over'".

Some people who used this service required support from care staff in handling their medicines. People told us that the care staff provided the support that they needed so that they received their medication as their doctor had prescribed. One person told us, "All the staff who come here have to be trained in how to administer my medication, I have never had anyone who hadn't known how to do this, the staff have all been trained".

The provider used safe recruitment systems when new staff were employed. All new staff had to provide references to confirm their previous conduct and experience. They also

Requires Improvement

Is the service safe?

had to obtain a Disclosure and Barring Service check. This checked that they had not been barred from working in a care service and that they did not have any criminal convictions which would make them unsuitable to in people's homes.

Requires Improvement

Is the service effective?

Our findings

Some of the people who used this service were living with a dementia. The manager of the service had not completed training in the Mental Capacity Act 2005. The manager told us that there was no one in the agency who was trained to advise staff on how to ensure the Mental Capacity Act 2005 Code of practice was followed.

We saw that people who were able to express their wishes had agreed to the care that they received. However we found that the provider did not have systems to ensure that the rights of people who could not make their own decisions were protected. Where people were not able to make decisions about their care the provider had not identified if anyone else had the legal right to make decisions on their behalf. We saw that the relatives of some people had made decisions about their care but the provider had not checked that the relatives had the legal right to make decisions on the individuals' behalf.

The care plan for one person was unclear as two relatives had given different instructions about how the person should be supported. The manager of the service did not know if either of the relatives had legal authority to make decisions on the person's behalf. The manager had not arranged a meeting with people who knew the individual to ensure that any decisions were made in their best interests. This meant people could not be confident that their rights would be protected if they were not able to make decisions about their own care.

We found that the registered person had not ensured that people's rights were protected. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that the staff who supported them had been trained to ensure they had the skills and knowledge to provide the care they required. They told us that no new staff worked on their own until they had completed training. One person told us, "The staff seem well trained and they train up the new ones [staff]". Another person said, "If there is someone new they come with an experienced carer [care worker], until they get them trained up".

Care staff we spoke with told us that they had to complete a range of training before they were allowed to work on their own in people's homes. They said that, where people had more complex needs, they had to complete additional training to ensure they had the skills required to support the individual. One staff member told us, "We have good training, we're not allowed to use equipment, like a hoist, or assist with complex care until we have done training and been assessed as competent".

People we spoke with told us that they were included all decisions about their care. They said that the staff who supported them asked for their consent before personal care was delivered. One person told us, "They [care staff] always ask before they do something". During our visits to people who used the service, we saw that the care staff were able to communicate with the people they were supporting and gave people choices about their lives in a way that they could understand.

Some people who used the service required support to prepare their meals. People told us that the staff gave them choices about the meals they prepared and said the staff were able to provide food that they enjoyed.

Most of the people we spoke with told us that they did not require support from care staff to see their doctor. One person said, "My daughter helps me if I need an appointment with my GP and will take me". Another person said, "I look after my own appointments". Two people told us that the staff who visited them helped them to see their doctor if they needed this support. One person said they had received good support from the care staff when they were unwell. They told us that the care staff had identified that they were ill and ensured they received the medical assistance they required.

Good

Is the service caring?

Our findings

People we spoke with told us that they received a good standard of care from the staff who visited them. They told us that the care staff were "kind and reliable" and said, "This is an excellent service, the carers, [care staff], are very kind".

People told us that they received support from a small team of care staff who knew them and how they wanted to be supported. They told us that they were included in decisions about the support they received. One person said, "I am fully involved in planning the care visits". Another person said, "I feel very secure in having them, it is a lifeline for me, they are very polite and pleasant workers I would not want to change them".

We saw that people who were able to express their wishes had been included in agreeing to the care they received. People's care plans had been reviewed regularly and they had been included in reviewing their own care plans. We saw that people were supported to express their views and included in decisions about their care. One person said, "The staff ask me what I want, and they always ask if there is anything I want them to do before they leave".

Everyone we spoke with said that the staff treated people with kindness and respect. One relative told us, "They, [care staff], always speak properly to [my relative], I feel happy that I know someone comes in". Another person said, "The staff are professional but friendly, they don't just come here and do a job, they give me time and we always have a laugh". People told us that they "valued" the staff who visited them and the relationships they had developed. One person said, "The visits are the highlight of my day, the girls, [care staff], are a joy to have in my home".

People told us that the staff ensured their privacy, dignity and independence were protected. They said that the staff ensured curtains and doors were closed when they received personal care. One person said, "It was strange at first when I had to have help with my care, but the staff soon put me at my ease, they do what I need but let me do what I can myself". Another person said, "They all know what to do, they draw the curtains and put the fire on before I get up so the room is private and warm before I come through, then they help me wash".

Care staff we spoke with said they knew how to protect people's personal information. One staff member said, "We know not to talk about one client in front of another, we have to keep confidential information to ourselves".

Requires Improvement

Is the service responsive?

Our findings

Although people told us that they were included in agreeing to the support they received we found that some aspects of the service were not responsive to people's needs. People did not always receive the care they needed because staff did not have accurate and detailed information about how to assist them.

Each person who used the service had a care plan which gave the care staff information about the support they needed. The manager of the agency told us that most of the people who used the service were living with some level of dementia. Although staff had received basic training around supporting people who were living with dementia we saw that there were no strategies in people's care records about how staff were to support people with aspects of their care. We found that some people had not received the support they required to meet their needs.

For example one person had been identified as at risk of dehydration if they did not drink enough. Their care plan stated that the care staff were to encourage the person to drink and were to monitor an aspect of their health which could indicate that they were not drinking enough. We saw that, although the person's care plan instructed staff to encourage the individual to drink, there was no guidance for the staff on how to do this. There were no instructions for staff on the action they needed to take if they identified that the person's health was deteriorating. Over a period of eight days this person's care records showed a change in their health that suggested they were not drinking enough. There was no evidence that the staff who visited them had taken appropriate action in response to the change in the person's health. The concerns had not been referred promptly to the health services that supported the individual.

This person's care records also showed that they required encouragement and direction to maintain their personal hygiene. Although their care plan instructed the care staff to assist with their personal care, there was no guidance on how they were to do this. There was no information for staff about how they should encourage or direct the person to ensure they maintained their personal hygiene.

We found that some care records were not accurate and up to date. One person's records stated that their relative had developed a detailed care plan for the staff to follow to support the individual. The manager told us that this plan was no longer being followed, but this was not clear from the records we saw.

We found that the registered person had not ensured that people received the care they required to meet their needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were included in all decisions about the support they received and said that the service was responsive to their wishes. They told us that if they requested any changes to their support action was taken to meet their wishes. One person told us, "I can change things if I want" and another person said, "Things are changed immediately if you ask".

Everyone we spoke with told us they were happy with the care that they received. They told us that the staff who visited them knew the support they required and provided this. One person told us, "I used to have care from a different agency, but they kept letting me down, this service is much better, the staff know the support I need and they never let me down".

The provider had a procedure for receiving and handling complaints about the service. People told us they had received a copy of the complaints procedure when they started to receive care from the service. People who used the service raised no complaints with us about the care they received. Two people told us that they had raised concerns with the service and said that these had been promptly resolved to their satisfaction. One person told us, "I only had to complain once, and that was about a new carer, [care worker], and it was dealt with promptly". Another person told us that they had requested for the time of one visit to be changed as it was too early and said, "I asked and it was put back to a reasonable time".

Requires Improvement

Is the service well-led?

Our findings

Although there were systems to assess the quality of the service provided we found that these were not effective. The provider had carried out their own audit of the service in August 2014. This had identified that risk assessments were not thorough or robust and that checks had not been carried out on the care records that care staff completed at each visit to a person. At our inspection visit in December 2014 we found that the provider had not ensured that action had been taken to address these issues.

We found that some risk assessments were not fully completed and others held inaccurate information. We saw that the risks to people of injury from falling or from hazards in their environment had not been managed effectively and people were not protected from harm.

We looked at the records that care staff had completed at each visit to a person. We saw that the care staff recorded the support that they had provided in a care record book that was held in the person's home. We looked at six care record books that had been completed and returned to the agency office. We saw that these had a section which was to be completed when they were checked by a senior person in the service. We found no checks had been recorded in any of the completed care record books that we looked at. The manager of the service told us that the provider's policy was that each care record book should have been checked. They said that the care record books had not been checked due to senior staff not having time to examine them.

Although the provider's own audit had identified concerns around the quality of risk assessments and that the care record books had not been checked as required, we found that action had not been taken to address these issues.

At our inspection we found that the processes used to assess the quality of the service had not ensured that people received the care they needed or that their rights were protected. We saw that care was not always planned to meet people's needs. We also found that the Mental Capacity Act 2005 Code of practice was not being followed.

We found that the systems used to assess the quality of the service had not ensured that people received safe care that met their needs and protected their rights. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was required to have a registered manager at this service. At the time we carried out our inspection there had been no registered manager at the service for over 12 months. A new manager had been employed in June 2014. When we carried out our first visit to the service in December 2014 the manager had not submitted an application for registration. We discussed this with the manager and advised them that an application for registration was required as the provider was in breach of their conditions of registration. When we returned to complete our inspection on 6 February 2015, the manager had still not submitted their application for registration.

This is a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009, because the provider did not have a registered manager in place at the service.

People who used the service told us that they were asked for their views of the care they received. Some people had been spoken to on the telephone and other people had been visited by a senior person from the service. People told us that if they requested any change to their care this was usually acted on. One person told us, "The supervisor comes and checks from time to time that all is well" and another person said, "If I ask for a change they help if they can".

A member of the agency management team carried out unannounced "spot checks" on care staff working in people's homes. People's records showed that they had been asked if they were happy for these spot checks to be carried out and said they had agreed to them. The checks were used to both provide support and supervision to staff and to assess the quality of the care provided by the staff.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had not ensured that risks to people's safety were identified and managed. People were not protected from the risk of harm. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider had not ensured that suitable arrangements were in place for obtaining consent on behalf of people who were not able to make their own decisions about their care. Regulation 11 (3).

Regulated activity	Regulation
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People were not protected against the risks of receiving inappropriate or unsafe care because care was not always planned in a way to meet their needs and ensure their welfare and safety. Regulation 9 (3) (a) (b).

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had not ensured that the systems used to monitor the quality of the service were effective. Regulation 17 (1).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 5 (Registration) Regulations 2009 Registered manager condition How the regulation was not being met: The provider did not have a registered manager in post. Regulation 5.