

Carewatch Care Services Limited

Carewatch (Wirral)

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on the 17, 24 and 31 August 2016, the first day was unannounced. On the 24 August we made arrangements to visit people who used the services of Carewatch Wirral. During our inspection Carewatch Wirral provided care to 204 people who lived in their own homes across the south of Wirral and North Cheshire.

At the time of our inspection there was a new manager in place. The manager was not registered with the Care Quality Commission; however they had started the process of registration.

We found breaches relating to complaints and lack of good governance. You can see what action we told the provider to take at the back of the full version of the report.

Information regarding complaints was either not recorded or was recorded in a way that didn't allow the manager to collect information, acknowledge the complaints and respond to them. There was no reviewing of complaints in order to assess potential problems and the quality of the service provided for people.

Information was not being used effectively. We saw occasions when important information regarding people and their care was not fed back to the office. We also saw occasions when information was fed back to the office and it had been recorded, but not effectively or in an appropriate place.

The systems for sharing important information were not working. The quality assurance systems had not picked up on this. Quality assurance visits to people's homes and reviews of people's care had not picked up on out of date, incorrect or incomplete information in people's care files. People's complaints and feedback. Differences in people's medication, MAR errors and incidents.

Some people's care plans were not being followed or did not have up to date information in them. Information was not always fed into them by the systems in place. At times the care plans did not provide enough information or guidance for care staff. The lack of information in place could have an impact on people's health and wellbeing.

The majority of the feedback from people was positive and people told us they were happy with their care. We saw and people told us of examples when care staff had gone above and beyond what people expected of them. Other people told us that the quality of the care they received varied from carer to carer. Some people told us they received care from familiar staff, others said staff varied a lot.

People told us they were treated with dignity and respect. We saw and were told that there were many positive relations between carers and the people they cared for. The office had received thank you cards and on one day we visited a bouquet of flowers.

The office received many phone calls and we saw that these were dealt with in a friendly manner and efficiently. When problems arose with people's visits staff were proactive with providing people with information and offering solutions.

We saw the system Carewatch Wirral had in place to ensure that no visits to people's homes were missed. Almost 100% of visits had an allocated carer on a roster system that was sent to each carers phone. Carers logged into and out of each call giving the office up to date information on the visits people were receiving. People told us Carewatch Wirral never missed a call. We saw that there were adequate numbers of staff to fulfil people's care needs.

Staff received a thorough induction which they praised. We saw that systems were in place to support staff members including training and periodic training refreshers, supervision meetings, in work assessments, staff meetings and annual appraisals. There was a senior member of staff available on-call 24hours a day. Staff received training in safeguarding vulnerable adults.

We saw that the language and descriptions of people used in people's care plans were respectful and sensitive to people's dignity. We found that the organisation operated within the principles of the Mental Capacity Act (2005), people's consent was sought for their care.

Some of the systems in the office worked effectively. Rosters and information relating to staff was clear and up to date. Training was up to date and in line with the organisations schedule. The manager had in place a 'service quality improvement plan' which outlined the performance of the organisation against key targets.

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.

Medication sometimes differed from the information in people's care plans. Medication administration records had not been consistently completed.

Incidents that happened during people's care were not consistently recorded.

People told us that carewatch Wirral was reliable and didn't miss calls. We saw that systems were in place to ensure visits to people's homes were made.

There were adequate numbers of staff within Carewatch Wirral to provide the care people needed.

People had been safely recruited. Staff received training in safeguarding vulnerable adults.

Is the service effective?

Good 

The service was effective.

New staff received a thorough induction and training which they praised. New staff initially worked alongside experienced members of staff.

Staff were supported with training refreshers, supervision meetings, staff team meetings and annual appraisals.

The service operated within the principles of the Mental Capacity Act (2005).

Is the service caring?

Good 

The service was caring.

The majority of the feedback from people and their families was that they felt well cared for. People had stated in feedback that they felt respected.

We saw and were told that there are many occasions when staff go out of their way to be kind and caring to people.

People told us there was a nice response from the office when they visited or called on the phone.

Is the service responsive?

The service was not always responsive.

Complaints had not been recorded or consistently responded to. No system was in place to learn from the feedback given by people using the service.

Language and descriptions used in people's care plans was respectful. However at times the care plans did not provide enough information or guidance for care staff. Care plans were not always up to date.

At times care was provided that did not reflect the person's care plan.

Feedback from people was not always acted upon.

Requires Improvement ●

Is the service well-led?

The service was not consistently well-led.

Systems for recording and sharing important information were not working effectively. Information was sometimes documented but held in such a way to not be effective.

Quality assurance audits had not highlighted problems. Systems in place were not being used effectively. This meant the manager didn't consistently have the information they needed to assess the quality and safety of the care provided to people.

The manager was open, candid and keen to improve. Some improvements had already started. Further ones were put in place during our inspection.

Requires Improvement ●

Carewatch (Wirral)

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 checked 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 17, 24 and 31 August 2016. The inspection was conducted by an adult social care inspector.

We spoke with ten people who use the services of Carewatch Wirral. We case tracked the care of five people looking at their care files, risk assessments, medication and feedback they had given to Carewatch Wirral. We then visited these five people and gained their feedback in person. We spoke to an additional five people on the telephone. We also spoke with four friends and relatives of people who use the service.

We spoke with 12 members of staff including the manager, care co-ordinator, two quality officers and five carers and three new starters. We looked at the staff files for five members of staff.

We checked the records held by the CQC relating to Carewatch Wirral and gained information from the local authorities Quality Assurance team. Before the inspection, we asked the provider to complete 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 used this information to help us plan our inspection.

Is the service safe?

Our findings

One person told us, "My care is ok, it's fine. They are reliable". We asked another person if they were reliable and they told us, "Oh yes, very reliable, absolutely. We are never missed out". A third person said, "They are very good, I feel safe with them".

One person's family member gave feedback to the office writing, 'I'm happy with the care mum gets on her daily visits. It has taken a lot of worry from me on the day's I can't get to mum. Thank you so much for your care. Now that the girls are going, mum takes her tablets every day which is wonderful and I have peace of mind'.

Some people offered care by Carewatch Wirral administered their own medication. Others were prompted and reminded to take their medication. For other people the carers administered the medication. If necessary the medication was in a locked cabinet. When staff administer or prompt the person to take their medication they record this on a medication administration record as administered.

We saw one person's medication in their care plan did not match the medication they were taking. Two medications they were being administered were of a stronger dose than what was documented in their care plan. There was no mention of a change to medication in the daily logs or in the care plan we looked at. The manager told us that new medication should be checked against information in the care plan by the carers when it arrived. This had not happened and there was no record of any call being made to the office to inform them of this.

There had been occurrences of people's medication administration record (MAR) not being completed correctly. We saw records from a staff meeting in September 2015 when a senior member of staff highlighted problems with carers not completing MAR charts correctly. We found that this had improved in the past two months, however there were still further improvements needed. For example with people's creams there was still a large number of blanks where it was not recorded if the cream had been applied or not applied. On one MAR sheet we saw two creams had been handwritten on by care staff that were not in a person's care plan. The office had not been informed of this change.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As the provider had not effectively monitored or audited the medicines being administered by the service.

There was a log of accidents and incidents held in the office of Carewatch Wirral. Those recorded for 2016 were three minor injuries to staff members and five events involving keys or mobile phones. We asked the manager if they recorded incidents elsewhere and she showed us six different entries for 2016 on the computer system, for incidents and complaints.

There had been a number of incidents that people told us about or we saw records about that had not been

recorded, or had been documented in ways not following the organisations system. The senior staff at Carewatch Wirral had no system that enabled them to review accidents or incidents. The manager was not able to look for themes, to assess risks, to assess the quality of the service provided for people, or to plan and make improvements. This meant that necessary improvements in a person's care may not be made.

People who wanted to apply for a role with in Carewatch Wirral completed an application form outlining their qualifications and experience. Applicants were invited to an interview which assessed their approach and skills. The organisation sought two references for people who had applied for the role of carer. We saw these references on people's files. On one person's file we saw that both the references were personal character references not from previous employers. There was no record of these references being verified or why a previous employer's reference was not available. We asked the manager to give attention to how they obtain and verify references, to ensure people were recruited safely.

Photographic identification and proof of address was sought along with the applicant's right to work in the UK. New staff had a criminal records check (DBS) completed by the organisation. Each year existing staff made an annual self-declaration as to the accuracy of the information held. A new DBS check was obtained every three years for each member of staff. New staff started on a three month probation period, which was reviewed at the end and successful staff became permanent members of staff.

People told us that Carewatch Wirral were a reliable organisation and didn't miss visits. We saw that the service had systems in place to ensure that people received their calls. Staff showed us a new system that had been in place from early August that helped to make sure the organisation didn't miss visits and had important information regarding times of calls to hand. Each person's care file had an electronic tag that the carer scanned with a mobile phone they had been provided with. They did this when they arrived and again when they left. This informed the system in the office that the call had been made. This replaced an earlier less reliable system where people called into a number to confirm the visit. We also saw the rostering system which showed in advance that visits to people's homes had been allocated to a staff member. In June this was 97% and in July this was 93% allocated to a staff member, the rest of the visits were completed by staff covering.

We saw that there were enough staff within the organisation to safely provide the care people needed. Those people whose care plans identified them as requiring the care from two people to remain safe, told us they always receive care from two people, without exception.

Staff wore uniforms identifying them as Carewatch staff. Staff were also provided with photographic identification to show to people who may not be familiar with them. On a recent survey answered by 20 people customers were asked; 'Do new care workers to you always identify themselves with an identity badge?' 70% of people selected sometimes or never. This had been identified as an area for improvement by the manager.

People told us that carers used gloves and aprons when offering personal care as appropriate. Carers we spoke with told us that the organisation supplied this equipment.

Staff received safeguarding training as part of their induction and had a refresher session each year. Staff we spoke with were aware of their responsibilities to report any concerns they may become aware of. Staff had been provided with a phone to call the office or an out of hours on-call service with any concerns they may have. The organisation had a safeguarding policy in place giving guidelines and contact details of outside organisations to staff.

We saw that if carers or quality officers identified that a person was at increased risk of fire at their property a referral was made to the local fire authority. We saw copies of these referrals on some people's files.

Is the service effective?

Our findings

One person said about the carers who came to their home, "They are a good crew, they make a good coffee". Another person told us, "We've got a good gang, I call them the A team, they are good lads". One person's family member said about the carers, "They are wonderful, put a big tick by their name". A staff member told us, "I really love the job, we get treated really well".

Staff told us they had a thorough induction into the organisation and their role. We spoke to three new members of staff who were part way through their induction process. The induction process involved four days classroom based training that had an accompanying learner's reference guide and learning workbook that new staff completed during the course. One of the staff members told us, "I've been to a few places and this is the best one for training". Another told us, "The training is brilliant, the trainer is really approachable, no question is silly". One staff member told us, "I had a good induction, I didn't feel rushed. I felt like I knew what I was doing when I went out to care for people".

The training included written and practical sessions including an orientation in care, first aid, pressure area awareness, equality and diversity, communication, privacy and dignity, safeguarding, infection control, health and safety, medication, nutrition and moving and positioning. After this training the new staff told us they will work alongside an experienced member of staff, until they are signed off as competent by a care coordinator. After 12 weeks in their role they finish the induction with day five of training. This focuses on caring for people with dementia in more depth and also a safeguarding refresher.

Longer standing staff had an annual refresher of core training that covered reminders of the information given to new staff members. We saw management training records which showed that all this training was up to date in line with the organisations schedule. Care staff had been supported to complete a National Vocational Qualification (NVQ) in health and social care.

People told us they received regular supervision meetings with their line manager to discuss their progress and any concerns the staff member may have. Staff also had regular 'field based observations' when their practice in the community was observed by a quality officer. The areas covered during this observation were, Communication, core values, reporting and recording, medication. A summary of the quality of the person's care was made and was fed back to the carer. We saw evidence of all these processes in staff member's files.

Staff had an annual appraisal with their line manager. This appraisal involved the staff contributing to the process by filling out a form assessing their own performance and the manager doing the same, before meeting together to discuss their performance. Staff told us and we saw records of staff meetings were matters were discussed relating to the carers role and the organisation, this was to keep staff informed and up to date as a group. We saw on staff members files a 'safe to practice workbook' which the carer completed giving them a comprehensive review of their role.

We discussed the requirements of the Mental Capacity Act (MCA) 2005, with the management team. The

Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. We found that the organisation operated within the principles of the Mental Capacity Act (2005). The manager told us that, and we saw that everybody cared for had the capacity and capability to live in their own homes alone or with their families. Carewatch Wirral provided brief visits to help people with specific tasks as agreed with the person. We saw that people's files had consent forms that had been signed agreeing to the care provided to them.

People told us that on occasions staff had expressed concerns that a person may be ill to their family member or people were supported to contact their GP. The organisation did not provide meals for people, but as part of their support would prepare or heat up a meal the person had in their home and make them a hot or cold drink.

Is the service caring?

Our findings

The majority of the feedback from people was that staff were caring. For example one person told us, "The girls that come out to the house are fantastic". Another person said, "They are friendly, I get on well with them. They are patient and polite". A third person stated, "[name] is great. He's a really good help. Sometimes I don't even have to ask, he just helps me out".

One family member told us, "They go beyond their care, they are wonderful with him. They really are a caring lot, it's a hard job". Another family member told us that their relative gets on very well with his carers and enjoys a laugh and joke with them. One family member wrote in feedback to a questionnaire, '[name] and I feel we are happy in our own home for we are respected by each carer'.

Some people told us the care they receive varies from carer to carer. For example one person told us, "Care standards drop with different carers". Another person told us, "It varies a lot from person to person".

On a recent survey answered by 20 people customers were asked; 'Do you feel care workers respect you and your home?' 95% of people selected the answer always or usually.

On our visits to people in their homes we spoke with a staff member who had just been to a local shop to pick up some orange juice. When we spoke with her she told us that during a morning visit she had noticed a person didn't have cold drinks in their home and it was a hot day. So on her way home she was dropping some off. She told us, "It's the least I can do". One person told us about their staff, "They make sure everything is right for you before they leave, they do everything they can".

We visited five people in their homes. Interactions that we saw with staff from Carewatch Wirral were caring and respectful. When we were visiting one person in their home their carer called them on the phone and asked if they needed anything from the shops on their way in. The conversation was pleasant and friendly between them. After the call the person told us, "Quite a few of them are helpful. One carer even organised for my vacuum cleaner to be fixed".

We saw a number of cards that had been sent into the office for the staff. One card read, 'To everyone, from the girls in the office on the phones, to all the different girls who looked after me. I couldn't have done it without you all, Thank you!' Another card read, 'To all my lovely ladies, thank you for your care and friendship over the past years, I'll miss you all'. On the third day of our visit a bouquet of flowers arrived for the staff in the office.

People told us they thought the service they received from the office was good. One person commented, "I call the office every day, they are so friendly. They sing with me on the phone. The office staff are so nice". Another person wrote in feedback, 'If I ring up because someone is late they never make me feel I am being a nuisance'.

We saw the staff in the office were respectful and courteous to people both in person and on the phone, the

office was busy and the phone rang often. On the third day of our visit there had been a road closure on a main route used by many carers in the morning, there was a diversion in place and traffic queues. We saw that when the office staff became aware of this they called carers to check their schedules and then called people to inform them if their morning visit was going to be much later than expected. They were friendly with people on the phone, showed concern and offered reassurance. One of the office staff went out to cover some morning visits, so some people didn't have to wait too long.

Is the service responsive?

Our findings

When we asked the manager to show us the complaints log there was six complaints and incidents recorded on their system for 2016. However during our inspection at Carewatch Wirral we became aware of complaints that had not been recorded on the system.

For example in one person's daily log books there had been written, '[name] was agitated on arrival. Annoyed with times of calls. Office informed as verbally aggressive. Meds taken. Reassurance given. Calmed [name] down, well on leave'. The manager checked the system in the office and there was no record of the call or the complaint. The daily log book containing this information had been audited by a senior member of staff stating, 'no concerns'.

Two people told us they had experienced difficulties with Carewatch in relation to payment arrangements. We were told that on both occasions carewatch had made mistakes and the people had raised complaints. One person received a letter acknowledging the mistake the other person did not. Both people did not receive an apology from Carewatch. These two events although known by Carewatch Wirral were not recorded in the complaints log.

We looked at the feedback from recent questionnaires sent out by the organisation to people using the service. A lot of this was positive. However in five people's feedback there had been specific complaints raised. These had not been recorded as complaints by the organisation and did not appear on the complaints log. There was a customer survey action plan for themes arising from people's answers but not regarding complaints.

The system available to record complaints was not being used to analyse or collect information. The manager said to us, "I can see that complaints are not being recorded effectively; I recognise this is a flaw and needs to be addressed". In feedback to a questionnaire one person's family member wrote, 'I have raised a number of issues and complaints with the office over the last six to eight months. These have not been fully resolved'. One person's family member called to inform Carewatch Wirral that a carer had missed a morning medication. This was resolved appropriately by the senior staff member. However in feedback to the family they were asked if they wanted to make an "official complaint". We informed the manager that all complaints should be investigated and recorded, not only those stated as official. One person told us that they had been apprehensive to make a complaint because they were not confident that it would be dealt with and may cause them trouble.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A system for documenting and responding to complaints was not being used.

We saw that the language and descriptions of people used in people's care plans were respectful and sensitive to people's dignity. This showed a good example for staff in how to record information about people in a respectful manner. However at times people's care plans were not being followed or were did

not have up to date information in them. Information was not always fed into them by the systems in place. At times the care plans did not provide enough information or guidance for care staff.

One person told us that some carers didn't follow their care plan and came to put them to bed too early. In particular this happened at the weekends and it was certain carers who did this. We looked at the schedule for the previous week and found that on three occasions the night-time carer for this person was forty five minutes, one hour and an hour and a half ahead of schedule. Two of these nights were on the weekend and all three of the visits were from the same carer as the person described. The manager told us she would look into this.

One person told us their morning visit was too late particularly on certain days when they had a lunch prepared for them. The quality officer called the person in October and again in November and on both occasions the person fed back that the morning call was too late on certain days. When we visited the calls were still at the same time and the person told us they were still too late. In the daily log for the morning of our visit it had been documented they had refused breakfast after 11:05 because they were going for dinner at 12:00. This person was diabetic and was on occasion missing meals due to the time of the call.

People's care plans documented the length of a person's visit and their care needs during each visit. We found some people were pleased with the lengths of their visits, others were not. One person told us, "Some rush around and go as fast as they can". We saw documented in daily logs that some people received considerably less than the time allocated to them. Some people told us that once tasks were completed they are ok with the carer leaving early. Others told us they wanted the time spent with them. One person who told us they need companionship had an average over a recent five day period of less than a quarter of the time stated in their care plan for their evening call.

On a recent survey answered by 20 people customers were asked; 'Do you know which care worker will be coming to each visit, except in emergencies?' 50% of people selected sometimes or never. We received mixed feedback from people. Some people told us they often received unfamiliar carers and this caused problems and other said they had a familiar and stable team. One person wrote to the office, 'Having [name] as a regular carer really helped, thank you'.

Another person told us, "I have familiar staff, every day the same people. A regular team, they are very reliable". Another person's family member's perspective was, "They are very good but they need to stick to the same people. Different faces coming in is all new to him, he finds it difficult".

Is the service well-led?

Our findings

We saw that often information regarding people and their care was not fed back to the office by care staff or the office staff had not recorded it effectively. The systems for sharing important information were not working. Information was fragmented and at times was not stored in a way that ensured it was useful to the office staff and managers. For example some medication errors had been documented and recorded on staff files and nowhere else.

We saw in a care file a body map that had been completed recording bruises on either side of a person's body. There was no record of any investigation that happened and there was no record of this on the organisations computer system as a potential incident.

One person had a letter in their care file in their home. An indicator of this person's health was their weight and a medical professional had left a letter for the carers and asked them to weigh the person twice a week, document their weight and alert them of any weight gain. The care staff had done this and there were records in the person's care file in their home. Since the weighing had taken place there had been notable weight gain but the senior staff at Carewatch Wirral did not know if any referral had been made. There was no mention of this task for the staff that had been in place for five months in the person's care plan. This had not been identified and documented during quality control visits by a senior staff member and subsequent reviews that had taken place. We highlighted this to the manager who was looking into this.

There was no centralised place to record incidents that happened within the organisation; therefore the manager was not able to assess the quality and safety of the care provided to people. There was missing information that could be used to inform the manager with regards to reoccurring risks and areas for improvement. Information that could be used to safeguard people could be missed.

People received quality assurance visits at least every six months in their homes, there were telephone checks completed in between these visits. These reviews had not picked up on out of date, incorrect or incomplete information in people's care files, complaints and feedback, differences in medication, MAR errors and incidents. Often these had not been fed into the organisations system or had been addressed and documented outside of the system.

In previous quality assurance visits there was no focus on the appropriate timing of visits or if visits were of an appropriate length as outlined in people's care plans. This information was not assessed by the organisation, even though this was an area that people mentioned in complaints and feedback. The manager told us that the new system where staff scan in using a mobile phone and information collected automatically will improve the information available to them in order to do this.

The manager told us that there had been a recent restructure of senior staff within the organisation, more quality officers had been appointed as there was a focus on the quality of the care provided. The organisation had started a new spot check system where quality officers visited and observed people's care in practice and recorded their observations. We saw some of these recorded on people's staff files.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of systems that would enable the manager to assess the quality and safety of the care provided to people.

Some of the systems at the organisation were effective. For example the manager had clear and up to date information to hand in relation to the support offered to care staff. For example the dates of previous and upcoming supervisions, observations and appraisals, who were due an end of probation review and who needed a renewed DBS check. The same system was in place for training, ensuring all training was up to date and for the completion of reviews of people's care files and telephone feedback. We saw a service quality improvement plan that outlined the performance of the organisation against key organisational targets.

We found the manager to be open, candid and keen to improve. When visiting people we saw that the manager was caring and interacted well with people and listened. The manager was responsive to the feedback and had already taken actions before the end of our inspection to record and address problems and complaints. One complaint had started being investigated thoroughly. Some of the issues the manager had already become aware of had plans that were already being implemented to make improvements. For example new guidelines and procedures on the administration of creams were being implemented in September 2016. A complaints log was in place at the end of our inspection and the system in place had started being used.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints A system for documenting and responding to complaints was not being used.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not being used that would enable the manager to assess the quality and safety of the care provided to people.