Olam Quality Care Ltd

Caremark (Ealing)

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 6 and 16 February 2015 and was announced. 48 hours' notice of the inspection was given because the service is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be available when the inspection took place.

Caremark (Ealing) is a domiciliary care agency that provides a range of care supports to adults and young people living in their own homes. At the time of our inspection the service provided personal care to 33 people.

At the previous inspection of this service on 14 and 21 August 2014 we found that the service was in breach of five regulations. These were in relation to care and welfare of people who use services, safeguarding of people who use services from abuse, staffing, supporting workers, and assessing and monitoring the quality of service provision. During this inspection we found that the provider had taken significant steps to improve the service in order to meet the compliance requirements identified at the previous inspection.

The Service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 who used the service and family members were positive about the service that was provided to them.

Records of administration of medicines were limited. Some staff members had not signed to confirm that they had safely administered medicines, and gaps in medicine administration records had not been explained.

People were protected from the risk of abuse. The provider had taken reasonable steps to identify potential areas of concern and prevent abuse from happening. Staff members demonstrated that they understood how to safeguard the people whom they were supporting. Training and information was provided to staff.

Risk assessments were up to date and contained detailed information for staff members in how to manage risk to the person they were supporting. Risk assessments and management plans had been updated to reflect changes in people's needs.

Staff recruitment processes were in place to ensure that workers employed at the service were suitable. Staffing rotas met the current support needs of people. Staff had access to management support at any time of day or night.

Staff training was generally good and met national standards for staff working in social care organisations. Induction training was refreshed regularly and enhanced by addition training sessions. The provider had recently provided opportunities for staff to undertake qualification training at levels two and three of the Quality Assessment Framework for staff working in social care. Staff members received regular supervision sessions with a manager.

Staff members that we spoke with understood the importance of capacity to consent, and we saw that information about consent was included in people's care plans. The provider had recently introduced training in respect of The Mental Capacity Act (2005).

Information regarding people's dietary needs was included in their care plans, and detailed guidance for staff was provided in order to ensure that they met these.

People who used the service and family members were positive about the care that they received. Staff members spoke positively and respectfully about their approaches to care, and the people that they provided care to.

Care plans were up to date and contained detailed information about people's care needs and how these would be supported. People who used the service and family members were positive about the quality of care that they received. The quality of care was monitored regularly through contact with people who used the service and family members where appropriate.

People who used the service knew what to do if they had a concern or complaint.

The service was well managed. Staff, service users and family members spoke positively about the management, and there was evidence that concerns raised at a previous inspection had been addressed promptly. A range of processes were in place to monitor the quality of the service.

We found that the registered person had not protected people against the risk of unsafe use and management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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?

Requires improvement

Aspects of the service were not safe. Records of administration of medicines had not always been signed or initialled by the staff member concerned and there were unexplained gaps in some medicines administration records.

Risk plans were up to date and included management plans that included detailed guidance for staff providing care.

Staff we spoke with understood the principles of safeguarding vulnerable adults, how to recognise the signs of abuse, and what to do if they had any concerns.

Is the service effective?

Good

The service was effective. People who used the service told us that they were happy with the support that they received.

Staff members received regular training and supervision.

Staff members understood what to do if they had concerns about people's capacity to consent to any care activity. The provider had recently introduced training about the requirements of The Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring. People who used the service spoke positively about staff members' approach to care, dignity and respect.

Staff members that we spoke with spoke positively about the people whom they supported and described positive approaches to care.

The provider had arrangements in place to ensure that people were matched to appropriate care staff, and to ensure that, wherever possible, people would not be supported by a carer that they were unfamiliar with should one of their regular carers be absent.

Is the service responsive?

Good

The service was responsive. Care plans were up to date and detailed information about how and when care should be provided. Care plans and assessments contained information about people's needs, interests and preferences.

People who used the service knew what to do if they had a complaint.

Is the service well-led?

Good

The service was well-led. There was a registered manager in place who had made significant changes to ensure that the service had addressed concerns raised at a previous inspection.

Summary of findings

People who used the service, their family members and staff spoke positively about the management of the service.

Effective quality assurance procedures were in place.

Caremark (Ealing)

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.

We visited Caremark (Ealing) on 6 and 16 February 2015 and reviewed records held by the service that included ten people's care records and seven staff records, along with records relating to management of the service. We also talked with staff on site on the days of our visits. In addition to this we made telephone contact with other staff members and people who used the service and family members. We spoke with three people who used the service, five family members, the registered manager for the service and five staff members. The inspection team consisted of a single inspector.

Before our inspection we reviewed the information that we held about the service. This included the report of the previous inspection of this service, notifications that we have received from the service, safeguarding referrals made by the provider, and the Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well, and the improvements that they plan to make. We also made contact with two key professionals from London Borough of Ealing Social Services.

Requires improvement

Is the service safe?

Our findings

People who used the service and their family members told us that they felt that the service is safe. Comments included, "my carer is always on time, or lets me know if they are running late," and, "if we have a concern, the manager is always able to come and talk to us to find ways of sorting the problem out."

Risk assessments for people who used the service had required improvement at the previous inspection during August 2014, as they lacked detail about how risks were to be managed. The risk assessments had subsequently been updated, and the risk management plans were detailed and contained step by step guidance for staff, including in information regarding communication approaches. For example, a number of risk assessments for moving and handling of people, not only provided personalised guidance regarding how each task should be managed, but also stressed the importance of staff members talking to the person about what was going to happen at each stage, and of checking that the person was comfortable.

Risk assessments also included information in respect of environmental risk, and safety of equipment. Staff members had received moving and handling training prior to working with people who required this support. We were told that this included an on-site observation by the manager, and that new workers were not "signed off" to work with a person who required support with mobility tasks until this had been carried out. We saw recorded evidence of both moving and handling training, and on site-observations in staff training records.

The registered manager told us that where people's needs had changed and there were safety issues with the current level of support, there was an immediate review of risk. The records reflected this, and we saw evidence of correspondence with the local authority team regarding arrangements to resolve any such issue. A staff member told us, "if I notice any changes, I inform the manager immediately."

Concerns about number and availability of staff were raised as a concern at our previous inspection during August 2014. This concern was particularly in relation to the number of missed or late calls.

The provider had since introduced a computerised system which monitored times of arrival and departure of care staff at the home of the person who was using the service. If a carer had not arrived within three minutes of the due time, an immediate alert was raised with the service, and the records that we saw showed that, on such occasions, the registered manager or another carer would make the care call to the person. The registered manager told us that some staff members had not always been good at informing the service or the person if they were running late for a call, but that this had improved significantly since the computerised system had been introduced. Following a recent incident where a care worker was regularly arriving over an hour too early for a morning call and had not informed the registered manager of this, weekly reviews of all calls logged by the monitoring system had been put in place.

The service had a policy and procedure for administration of medicines, and staff members were not approved to administer medicines until they had received training in safe administration of medicines. This training was followed by an on-site observation of practice. However we had concerns about the recording of administration of medicines. We looked at five medicine administration records, and saw that, for four of these, ticks rather than initials had been entered to indicate that medicines had been taken. Two of the records also contained gaps where a reason for non-administration had not been entered. This was not consistent with the service's policy and procedure on recording of medicines. It also meant that the provider could not be sure that people were protected against risks associated with unsafe administration of medicines.

This was a breach of regulation 13 of The Health and Social Care Act (Regulated Activities) 2010 which corresponds to regulation 12 (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an up- to-date safeguarding policy and procedure. Staff that we spoke with were able to describe types of abuse, the signs and indicators that might indicate abuse and what they should do if they had a safeguarding concern. Training records showed that all staff had received training in safeguarding of vulnerable adults and children, and this was supported by written information, receipt of which had been signed for by staff.

We looked at seven staff files. Staff recruitment records included copies of identification documents, evidence of eligibility to work in the UK, two written references, application forms and criminal record checks. Staff files

Requires improvement

Is the service safe?

also contained recruitment details, training certificates and supervision records. We saw evidence that staff members were not assigned work until the service had received satisfactory criminal records clearance from the Disclosure and Barring Service.

All staff had received training on infection control procedures and were provided with disposable gloves and aprons, along with information regarding safe disposal of these and other relevant waste. We saw that stocks of these were held at the office and staff members that we spoke with told us that they went into the office regularly to obtain new supplies.

Records of accidents and incidents were viewed and we saw that these had been reported immediately to the service. We also saw evidence that these had been reported to the relevant local authority team.

The service maintained a 24 hour on-call service. Staff members and people who used the service and their family members told us that they knew what this was and would use it if they had any concerns and needed to speak with a manager. The provider also had a business continuity plan in place that included, for example, actions to be taken in case of severe weather conditions, pandemics, office closure and significant traffic delays.

Good

Is the service effective?

Our findings

People who used the service were positive about the support that they received from staff. We were told, "my carer is very good," and, "they are very flexible." A family member told us, "there has been a big improvement in the staff they send to us."

Staff training and supervision had required improvement at the previous inspection in August 2014. The registered manager had subsequently put improvements in place to address our concerns,

Staff members received classroom based induction training prior to working with any person who used the service. This followed a competency based framework that was linked to the Skills for Care Common Induction Standards for workers in social care services. The registered manager was aware of the new Care Certificate that will be in place from April 2015, and the records of recent induction training reflected the requirements of this. We spoke with one staff member who had recently been employed by the service, and they told us that the training had been helpful in giving them grounding in the information and skills that they needed before they commenced working. The training records showed that training in core skills and knowledge was regularly updated for workers, and we saw that additional training was provided, for example, staff had attended training in safe administration of medicines provided by Ealing Social Services. We also saw that a number of staff had recently been registered to commence training towards a Quality Assessment Framework qualification with a local training provider.

Staff supervision by a manager took place every two months, but more frequently during the induction period or where there were concerns about performance. Staff members that we spoke with told us that they spoke to a manager on a regular basis. One told us that, "if I want to discuss something, I know that I can come into the office and speak to my manager." There was evidence that new staff members were now subject to a monitored probationary period. An appraisal process had been put in place, and we saw that some staff had received performance appraisals. The registered manager told us that appraisals would take place for all staff members on the yearly anniversary of their commencement of employment with the service, and annually thereafter.

Team meetings had not taken place regularly. The registered manager told us that it was difficult to get staff together in the same place unless there was a training session. However, they told us that they would make arrangements for regular team meetings to take place for those who could attend and ensure that other staff members received copies of minutes of such meetings.

Understanding of the Mental Capacity Act (2015) in respect of people who used the service had required improvement at the previous inspection during August 2014, We viewed ten care files for people who used the service and saw that information about the person's capacity was contained within these. The majority of care plans had been signed by the person or a representative. The service had a policy and procedure on Capacity and Consent that followed the requirements of The Mental Capacity Act (2005). This highlighted the importance of involving other key people in decision making where appropriate for someone who has been assessed as lacking capacity.

The service had recently provided staff with information about their responsibilities in relation to The Mental Capacity Act, and we saw copies of this, along with evidence that staff members had signed to confirm receipt of this. Capacity and consent were also now included in the training programme for the service. We asked staff members what they would do if a person appeared to lack capacity to consent to any decision. All told us that they would try their best to find ways of communicating with the person and refer to their manager if this was unsuccessful. One told us, "I would try to find other ways of helping them understand, and I would talk to my manager if I thought there were any changes in their being able to work things out." Staff members that we spoke with knew what capacity was, and were able to describe their responsibilities.

Care plans and risk assessments for people who were being supported with eating and drinking were clear about the reasons why support was required and provided guidance for care staff about how to support people with these tasks. This included information about preferred food and drink, where and how they should be supported and what to do if there were any concerns. We saw that some plans also included guidance for staff around ensuring that people had access to drinks and/or snacks within easy reach during times that they were alone.

Good

Is the service caring?

Our findings

People and family members that we spoke with told us that they considered that the service was caring. One person said, “she is very good. She listens to me and does what I ask.” A family member said, “we had problems in the past, but the carers are really good now. They seem to really care.”

We were unable to see care being carried out, but the staff members that we spoke with talked about the people whom they supported in a positive, caring and respectful way. One told us, “I know that if I talk to people about things they are interested in, especially when doing personal care, this makes a big difference to them.” Another said, “sometimes people are stressed out, but I understand why this happens, and it’s my job to try not to increase the stress.”

Some staff members told us that it was important that people received care from staff whom they were familiar with, and that there was always another person known to the person who used the service who could provide care if a team member was on leave or off sick. The registered manager confirmed this approach, telling us that that, in order to achieve this, the service did not rely on one or two people to provide care to a person, but ensured that other workers were also involved to ensure that there was continuity of support if a team member was absent. They also told us that, wherever possible, staff members were matched to people who used the service, and that this might be on the basis, for example, of age, gender, language or interests. People that we spoke with confirmed that care was provided by a worker that was known to them. “We are usually told when someone is going on holiday, they try to give us someone we already know.”

The registered manager told us that new staff members, or those new to the person who used the service, would shadow established staff members in order to understand the person’s needs and establish a relationship with them. One staff member told us that they valued this opportunity, “as I can learn a lot more about the person than what is written in their care plan.”

We asked about approaches to dignity and privacy. One person told us, “they always make sure that I am covered up as much as possible when they are washing me,” and a family member told us, “the workers we have are very respectful.” Staff members told us that they received training about dignity in care at induction and this was confirmed by the training records. The registered manager showed us that the service had recently signed up to The Dignity in Care Network and told us that the Ten Point Dignity in Care Challenge standards were being circulated to all staff and would be discussed at future supervision meetings.

Good

Is the service responsive?

Our findings

People who used the service and family members told us that they were pleased with the service. One person said, “they ask me about what I need and are good at doing things the way I want.” A family member told us, “when we asked for a change of time, the manager helped us make sure this happened.”

The quality and detail of care planning had been raised as a concern at our previous inspection in August 2014. During this inspection we reviewed nine care plans, and saw that these had all been updated recently. The care documentation that we viewed showed that improvements had been made.

Care documentation included revised assessments of people’s care needs that were linked the local authority care plan. These also contained information about people’s living arrangements, family and other relationships, personal history, interests, preferences and cultural and communication needs. The assessments also included information about other key professionals providing services or support to the person.

The care plans that we saw were clearly linked to the assessments, and to risk assessments for specific activities. We saw that care plans provided information about each task, along with detailed guidance for care staff about how they should support the person with these. For example, one care indicated clearly how staff should support a person recovering from a stroke to maintain and develop independence. Another provided guidance for staff supporting a person to use the community who was dog phobic in how to respond to the person’s anxieties if they saw a dog.

There was evidence that care plans had been reviewed and updated to reflect changes in people’s needs, for example for a person with dementia, where new risks had been identified, and that the service had liaised with family members, and other key professionals to agree new approaches to care.

Records showed that people who used the service, or their family carers where appropriate, were contacted regularly by telephone or through a personal visit to assess their views about the quality of care provided by the service. The registered manager also undertook spot check of care through unannounced visits to the person’s home just before, or at the time care was due to be provided, and we saw records of these checks. People that we spoke with said that they appreciated the fact that they were being asked for their views. One person said, “it makes me feel confident to know that they are interested in me and what I think.”

The service had a complaints procedure that was available in an easy read format. The registered manager told us that they would provide this in other formats should this be required. People that we spoke with said they understood the complaints procedure and told us that if they had a complaint about the service, they would raise this with the manager. When asked about what they would do if they felt a complaint hadn’t been addressed, we were told, “I would talk to social services,” and “I would contact the Care Quality Commission.” People were generally positive that any complaint would be addressed immediately by the registered manager of the service. We were told that, “She’s very good. She comes and speaks to us straight away if we have a problem.”

The record of complaints, concerns and compliments maintained by the service showed that recent complaints had been addressed at the first stage of the complaints procedure.

Good

Is the service well-led?

Our findings

People who used the service and their family members spoke highly of the management of the service. We were told, “We can always contact the manager if we have any concerns,” and, “the manager helped me to make changes to my care.”

Quality assurance processes had been raised as a concern at our previous inspection in August 2014. We saw that improvements had been made to these to ensure that the service was able to demonstrate that quality issues were being monitored, recorded and addressed.

The care files that we viewed showed that quality assurance processes such as on-site spot monitoring, telephone checks with people who used the service, and home visits by the registered manager to check on people’s views of the service had been increased. People that we spoke with told us that the registered manager had been in contact to establish their views about the service. A family member that we spoke with said, “the manager came out and asked us what we thought. That was good.”

We saw evidence that other quality assurance processes were in place. For example, monthly provider visits where key service outcomes were reviewed and outcomes set, where progress against these were monitored at the next monthly visit. Regular spot checks of home visits were also in place. The registered manager told us that when these checks were undertaken, these were planned with the person but unknown to staff. One staff member that we spoke with told us, “the manager was there when I arrived and I wasn’t expecting this, but I didn’t have a problem with it as I believe that I do everything correctly.”

We saw evidence that service satisfaction questionnaires had been sent out to people who used the service or family members where appropriate. The returned questionnaires that we saw indicated high levels of satisfaction with the service.

The registered manager told us that monitoring of staff recording of visits had recently commenced and there was some evidence of this. Monitoring of call times was in place following the recent introduction of the computerised call system.

People who used the service and their family members were aware of who the registered manager was and spoke positively about them. Staff members were also positive about the registered manager, and felt that they were well supported.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who use services were not protected against the risks associated with unsafe administration of medicines because of inadequate recording of medicines administered.