Williams CM Ltd

Caremark (Walsall & Wolverhampton)

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**

Summary of findings

Overall summary

This inspection took place on 7 and 8 February 2017 and was announced. This location has not been previously inspected under the current ownership.

Caremark (Walsall & Wolverhampton) is a domiciliary care agency that is registered to provide personal care. At the time of the inspection the service was providing support to 89 people living in their own homes, most of whom were older people. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a 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 protected by a staff team who could describe the signs of potential abuse and knew how to report concerns. However, we found concerns were not always consistently reported by staff. Staff could describe how to manage risks to people while delivering care. Accidents and incidents were recorded and reported. However, the management team were not always completing effective reviews of the actions taken by staff to ensure people were kept safe.

People told us there were sufficient numbers of staff but they did not always receive their care visits at the time they needed them. Pre-employment checks were completed before care staff started work to ensure they were suitable to work with vulnerable adults. People were happy with the support they received with their medicines. We found the registered manager was not always able to confirm people had received their medicines as prescribed. This was due to issues such as gaps in medicines records not being investigated and resolved.

People were not always fully enabled to consent to the care they received. Where people lacked mental capacity decisions had not always been made on their behalf using the principles of the Mental Capacity Act 2005. People were happy with the skills and experience of their care staff. They told us they were also happy with the support they received with their food and drink.

People told us they were supported by a care staff team who were kind and caring towards them. People were treated with dignity and respect. People were encouraged to make choices about the day to day care they received and their independence was promoted.

People told us they had raised concerns with office staff and did not feel their concerns had been listened to or appropriately responded to. We did however see that where the management team were made aware of formal complaints these were investigated and responded to. Relatives told us they were fully involved in developing care plans however people were not always aware of their own care plan. We found care plans were in place that reflected people's preferences and these were regularly reviewed. Care plans did not always clearly outline all actions required by care staff to meet people's needs.

People told us they were happy with the service they received from care staff and most people knew who the manager was. They told us improvements were needed in communication with the office team. People were cared for by a staff team who were motivated in their roles and felt supported by the management team.

We found quality assurance systems were in place but these were not always effective in identifying the areas of improvement required in the service. Where some issues and concerns were identified these were not investigated and resolved in a timely way in order to reduce risks to people and ensure they were receiving the care they required.

We found the provider was not meeting the regulations relating to the submission of statutory notifications to CQC and the effective management of the service. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe

People told us they did not always receive their care visits at the required times but there were sufficient numbers of care staff available. The registered manager was not always able to confirm people had received their medicines as prescribed.

People were protected by a staff team who could describe the signs of potential abuse. However, concerns about people were not always reported by staff. Staff could describe how to manage risks to people while delivering care, however, managers had not always ensured appropriate action was taken to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always fully enabled to consent to the care they received. Where people lacked mental capacity decisions had not always been made on their behalf using the principles of the Mental Capacity Act 2005. People were happy with the skills and experience of their care staff. They told us they were also happy with the support they received with their food and drink.

Is the service caring?

Good

The service was caring.

People told us they were supported by a care staff team who were kind and caring towards them. People were treated with dignity and respect. People were encouraged to make choices about the day to day care they received and their independence was promoted.

Is the service responsive?

Requires Improvement

The service was responsive.

People did not always feel concerns raised with office staff had been listened to or appropriately responded to.

Relatives told us they were fully involved in developing care plans however people were not always aware of their own care plan. People's care plans were regularly reviewed but did not always outline actions required by care staff.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

We found quality assurance systems were in place but these were not always effective in identifying the areas of improvement required in the service. Where some issues and concerns were identified these were not investigated and resolved in a timely way in order to reduce risks to people and ensure they were receiving the care they required.

People told us they were happy with the service they received from care staff and most people knew who the manager was. People were cared for by a staff team who were motivated in their roles and felt supported by the management team.

Caremark (Walsall & Wolverhampton)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 8 February 2017 and was announced. We gave the provider 48 hours notice of the inspection because it is a domiciliary care agency and we needed to be sure that the registered manager and staff would be available to speak to. The inspection team consisted of one 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.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

As part of the inspection we spoke with nine people who used the service and eight relatives. We spoke with the provider, the registered manager, the quality and compliance manager, the two care coordinators and five care staff. We reviewed four people's care records including their medicine administration records, three staff files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt staff understood the risks to them and knew how to protect them from potential injury or harm. For example, one person told us, "[Staff] use a key safe so I can keep my door locked". Relatives also supported this view. One family member told us, "They make sure [my relative] uses [their] walking frame safely". Another relative told us, "[Staff] use the hoist safely". Staff we spoke with could describe the potential risks to people and were able to tell us how they worked in ways to reduce the risk of injury or harm. However, we found staff did not always escalate concerns about people's safety to the registered manager resulting in people being exposed to the risk of harm. For example; staff had failed to report the potential need for equipment to keep a person safe while being supported to move. We did find the registered manager took appropriate action to escalate concerns, provide extra training or take disciplinary action when issues were identified. We found risk assessments were in place which identified risks to people and how to manage these risks although this was not always consistent. For example, we saw that in some cases the actions required to be taken by staff to manage some risks were not always clearly documented. We found staff were providing support to someone with complex mental health issues who could demonstrate behaviours that challenged. The steps taken by staff to keep this person safe were not recorded although the person was kept safe from harm.

Staff we spoke with told us they understood how to report accidents and incidents. We saw that accidents and incidents were reported to the registered manager. We did see however, that actions taken by care staff were not always reviewed to ensured people were kept safe. For example, while the registered manager told us care staff should not assist people to stand after a fall and should call 999, we saw care staff had assisted one person to stand. They had not sought medical assistance and this had not been identified through effective reviews of accident reports. As a result actions had not been taken to ensure this person had not suffered any harm and steps had not been taken to reduce the risk of any further harm.

People told us they felt safe with care staff. One person told us, "I feel safe when they are here". Staff we spoke with could describe how they would identify signs of abuse and how they would report any concerns about people. Staff knew how to whistleblow if this was required. Whistleblowing is when staff report concerns outside of the service to organisations such as the local authority or CQC. We saw that staff reported allegations of potential abuse however this was not always consistent. For example; staff had failed to report concerns about staff moving people in a way that may result in injury. Where concerns were reported, we saw the registered manager ensured concerns were reported to the local safeguarding authority and the police where appropriate. The registered manager was taking action including providing further training and taking disciplinary action where appropriate to ensure staff reported concerns in a timely way.

People told us they had consistent care staff and had not had any missed care visits. Some people told us while they felt there were sufficient numbers of staff, they did not always arrive at their expected time. Relatives told us this sometimes exposed people to risk as they would try to complete their own care. One relative told us, "They don't always let [my relative] know if they are running late. [My relative] gets anxious and will try to do things for [themselves]". The provider told us they were not using systems to monitor the

timekeeping of care staff. This meant we were not able to effectively review the extent of the issues relating to staff time keeping. We raised these concerns with the registered manager and provider who advised they would ensure appropriate action was taken to address this issue.
We looked at how the provider and registered manager ensured care staff were recruited safely for their role. We saw a range of pre-employment checks were completed before care staff began work including identity checks, references and Disclosure and Barring Service (DBS) checks. A DBS check allows employers to review a potential employees criminal history to ensure they are suitable for employment. We found one example where a referee had provided dates of employment that were different to those declared by the staff member on their application form. This showed us that while recruitment checks were in place and were mostly effective, where discrepancies required further investigation this was not always completed to ensure staff were suitable for the role.

People told us they were happy with the support they received with their medicines. One person told us, "[Care staff] make sure I have my tablets and put it in the book before they leave". Another person told us, "Everything is ok with my medication. No problems at all". Staff we spoke with could describe how they took steps to make sure people received their medicines safely. One member of staff told us how they always checked the labels on medicines as, "If [people are] living with someone else [medicines] might get mixed up". Another staff member told us how they rotated someone's pain relief patches to reduce any side effects such as skin irritation. We did however find that care staff did not fully understand how and when to administer 'as required' medicines. Some staff members did not understand what 'as required' medicines were. There were also no guidelines in place for staff to outline how these medicines should be given to people when needed. The registered manager confirmed they would resolve this and ensure instructions were developed as a matter of urgency following the inspection.

We did see that medicines administration records (MAR) indicated that people were mostly getting their medicines as prescribed. However, we did identify some improvements were required. For example; we saw care staff had altered the dosage of a prescribed medicine. While care staff believed this instruction had been agreed with the doctor, they were not certain this was the case. There was no record in the person's care records of this change. The registered manager advised they would complete investigations following the inspection to confirm this change in medicine had been agreed with the doctor. As a result we could not be certain this person was receiving their medicine as required. We also found that gaps in some people's MAR charts had been identified. Some gaps in administration dating back to November still had not been resolved at the time of the inspection. As a result, the registered manager could not confirm that some people had received their medicine as prescribed. This showed us that effective systems were not always in place to ensure people were receiving their medicines as required and any errors were identified and resolved promptly.

Requires Improvement

Is the service effective?

Our findings

People gave us mixed views about whether staff asked for their consent before providing support. While some people told us care staff always spoke to them and made sure it was ok to complete certain tasks, others said they did not. One person said, "I can't remember them asking me, no". Staff we spoke with told us they understood how to obtain consent from people before providing support. One staff member said, "First we ask them if we can carry out what we need to do". Another staff member told us how they respected people if they did not provide consent. They told us, "If they say no, it's got to be a no". We saw that consent to some people's care plans had not been sought from the person or a representative with the appropriate legal authority to consent on the person's behalf. Staff did not always have a consistent approach in ensuring people consented to the care they received.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff we spoke with were aware of the MCA and knew some of the basic principles such as starting with the assumption that people have capacity to make decisions and provide consent. However, staff did not understand how to apply the MCA in their work where people demonstrated a lack of capacity to make a specific decision or provide consent. Staff we spoke with, the registered manager and quality and compliance manager were not aware of the 'two stage capacity' test used to determine capacity around a specific decision under the MCA. Staff told us they had not been trained in MCA and records we looked at confirmed this. While we saw that some decisions were being made on behalf of people without the principles of the MCA being followed, we did see that staff were often speaking with relatives to make some decisions in people's best interests. For example, one person's care plan outlined how one person liked a specific bedtime drink but they often forgot this. Staff were asked to prompt this person to remind them about their drink as they knew this was something the person liked to have. Staff could also describe how they supported and encouraged people to complete care tasks to ensure their needs were met without unnecessary restrictions. The registered manager need to ensure that staff and management knowledge was improved to ensure good practice was consistent across the service.

People told us they were happy with the support they received with their food and drink. Relatives also told us they were happy with support provided. One relative told us, "[There's] no problem at all with [my relative's] meals". We saw care plans detailed people's individual's preferences about the food and drink they required. For example, one care plan identified that one person sometimes liked a jam sandwich after they had eaten their cereal at breakfast time. Staff we spoke with could describe the support people needed to meet their nutritional needs. We found care plans were not always clear about the actions required by care staff where additional support was required. For example, where food and drink needed to be monitored or where people received nutritional supplements. However, we found care staff understood people's needs and these were being met.

Most people told us they managed their own healthcare needs and appointments or they received support

from their relatives. We did however see that care staff did seek healthcare intervention where this has been identified as required.

People told us they thought care staff had the skills needed to support them effectively. One person told us, "[Care staff] are very skilled. Excellent carers!". Another person told us, "They are brilliant carers. All very good." Relatives also told us they felt most care staff had the skills needed to support people effectively and were well trained. Staff told us they received good training and support. A staff member told us, "I love my training, I really do". Another staff member told us, "[Staff name] is a really good trainer". They told us if they needed further training this would be sourced for them. They also told us if they were unsure of something they would get extra help. For example, one staff member told us, "If you are unsure of the hoist you can come in and run through it". We saw there was a bed and a mobile hoist in the office that was used for training purposes. Staff told us they had regular one to one meetings with their line manager and could access support when needed. We saw from staff files that regular one to one meetings and appraisals were held with staff members. We saw from training records that regular training was provided to staff and found that additional specialist training was provided where needed. For example, the district nurse provided training and supervision to staff around wound care for one person and 'peg' feeding training was provided to some staff. 'Peg' feeding is where people require food and medicines through a tube directly into their stomach. We did see however that staff and management had insufficient training, knowledge and skills around the Mental Capacity Act 2005. The principles of the MCA had not been applied when making decisions about people's care.

Good

Is the service caring?

Our findings

People told us they felt care staff were kind, caring and spent time talking with them. One person told us, "They talk to me all the time". Another person told us, "The carers are brilliant. Polite, helpful, courteous and will do anything for you". Relatives also told us care staff were caring. One relative told us, "[Care staff] are lovely, very caring". Another relative told us, "The carers are lovely. [My relative] likes them very much. They are really caring and [my relative] looks forward to them coming". Care staff we spoke with were demonstrated a commitment to their roles and told us they were passionate about the work they did. One member of staff told us, "I love being able to help [people] live as long as they can in their own home". Staff told us how they understood the importance of being caring towards people. Another member of care staff told us, "What they want more than anything is someone to listen to them, talk to them, explain things to them". Care staff took the time to get to know people and their preferences. One member of care staff told us how they spoke with one person about their past history when they were anxious. They told us, "Talking about this calms [the person] down". People and their relatives also told us the registered manager was kind and caring towards them and tried to help them. We did receive some comments that office staff were not always caring in their approach. The registered manager told us they would address this immediately. People were however supported by a management and care staff team who were kind and caring in their approach to them.

People told us they felt valued and respected by care staff. One person told us, "I feel very valued by them. They are very respectful when they are talking to me". Another person told us, "They are respectful when they speak to me. They know me well and chat while they write in the book [care records]". Care staff told us they felt listening to people, offering and respecting their choices and promoting their independence helped people to feel valued and imported. One member of care staff told us, "It's giving them choices. It can be anything such as what they want to eat or what they'd like to wear". They also told us, "We try to encourage them to do things for themselves". Another member of care staff told us about one person whose relative drew up a menu plan for them each week. Care staff told us they knew it was important to still ask the person what they wanted and to make any changes to the plan needed to meet the person's daily preferences. We saw care records encouraged care staff to respect people's choices where they had capacity to make them. For example, one care plan included details such as one person could frequently change their mind about whether they wanted sugar in their drinks. The care plan asked care staff to ensure they checked with the person what their choice was each time they prepared a drink for them. This was supported by what people told us about the care they receive. People's choices were respected and their independence promoted.

People told us their privacy and dignity was respected by care staff. One person told us, "[Care staff] help me have a wash and they do respect my privacy". Care staff told us they always tried to cover up people while they completed personal care and asked relatives to wait in another room where appropriate. This was supported by what we were told. One relative told us, "They always cover [my relative] with a towel whenever possible when they are washing [them]." Care records we looked at documented the ways in which care staff should work to promote people's privacy and dignity. For example, one care plan we saw talked about how care staff should assist someone onto their bed pan and then leave the room. This

showed us that care staff were encouraged by the registered manager to protect people's privacy and dignity wherever possible.

Requires Improvement

Is the service responsive?

Our findings

People told us they raised complaints with the service but felt their concerns were not addressed or responded to appropriately. One person told us, "I ring the office although they never ring me back". Relatives also told us they had raised complaints but they had not received a response. One relative told us, "I complained this week about the times changing. I have not heard anything but they never pass messages on". Another relative told us, "If I had any problems I would ring the office. It has happened, but they did not pass the information on". Care staff we spoke with could tell us how they would handle any complaints received directly from people. Records we looked at showed that formal complaints were investigated and a response provided in a timely manner. However, the view of people using the service and their relatives was that informal complaints made to the office were not always reported, escalated or investigated. This meant some complaints were not resolved and addressed appropriately.

People told us they did not always receive their care visits at the time they needed. One person told us, "[Care staff] arrive far too late. An hour and a half sometimes!". Another person told us, "[Care staff] can be late sometimes. They don't always let me know". Relatives also told us care visits were not always at the time required. One relative told us, "[Care staff] don't always arrive on time. They don't let [my relative] know and [they] get quite anxious waiting for them." Another relative told us, "The times can vary. They do arrive at different times". Care plans detailed the time people wanted their care visit. However, the provider and registered manager had not ensured people's needs and preferences were met around the time they received their care visits. We shared the feedback we received from people with the provider and registered manager who said they would look into the concerns and take the necessary action to address this.

Some people told us they were not aware of their care plan. Relatives we spoke with told us people did have care plans in place and these were reviewed regularly, however, people themselves were not always sufficiently involved. One relative told us, "[My relative] has a plan and they come to review it regularly". Another relative told us, "[My relative] has [a care plan]. It was reviewed before Christmas and I was involved". Care staff told us they felt care plans were reviewed regularly and kept up to date. Staff told us that people's changing needs were assessed and documented promptly. One staff member said, "We talk to our clients. They give us little things, we tell these to [the office] and it gets added to the plan". We saw care plans were in place and included information about people's preferences. For example, we saw details including where one person wanted their newspaper leaving, their past hobbies and information about their preference for apple sandwiches. We found some care plans were not clear about the tasks completed by family members or care staff. For example, some care plans and care records indicated that people required nutritional supplements and that care staff were administering these. Care staff and managers however told us these had been managed by the family. We also found that one care plan did not contain information about medicines administration completed by care staff. While care staff understood their responsibilities and how to care for people, the registered manager confirmed they would ensure care plans clearly outlined the responsibilities of care staff.

Requires Improvement

Is the service well-led?

Our findings

The provider and registered manager are required by law to submit statutory notifications to CQC when significant incidents arise at the service. We identified multiple allegations of potential abuse and incidents involving police had occurred. The provider and registered manager had failed to submit the required notifications.

This was a breach of Regulation 18 of the Care Quality Commission (Registraton) Regulations 2009 Notification of other incidents

We looked at how the provider and registered manager monitored the quality of the service provided to people and how they made any required improvements. We found that auditing and quality monitoring systems were in place however these were not always effective in identifying where improvements were required. For example; we found systems were in place to monitor any errors or concerns recorded in daily care logs and medicines administration records. However, these records were not reviewed in a timely way and any issues identified were not investigated immediately. This meant that concerns such as gaps in people's medicines administration records dating back to November 2016 still had not been resolved at the time of the inspection in February 2017. The provider and registered manager had not developed systems to ensure concerns about the care people received were identified and resolved in a timely way. We saw audits were completed on safeguarding, incident and accident records. However, as information relating to these significant events were not recorded accurately in one place, audits did not capture all relevant information. As a result the required areas of improvement in the service were not identified. Records relating to safeguarding incidents did not always indicate staff had taken appropriate action. We confirmed with the quality and compliance manager that the correct action had been completed although records did not always reflect this. Audits completed reviewed the number of incidents but did not identify areas of improvement that were required to reduce the potential future risks to people using the service.

The registered manager had not ensured that systems were in place to monitor certain risks to people. For example, one person required support from care staff to withdraw money and complete shopping. There were no systems in place to monitor the financial transactions completed by care staff to ensure the person's money was being managed appropriately and to reduce the risk of abuse. We also found that where high risk medicines were administered effective systems were not in place to monitor their administration. For example, one person had been receiving care from the service since mid December 2016 and required care staff to administer their warfarin. Any errors or ommissions with the administration of warfarin can lead to significant harm to a person's health, including the risk of death. The registered manager had not developed a system to ensure the medicines administration systems for this person had been reviewed. As a result they were not able to confirm if this medicine had been administered correctly at the time of the inspection, seven weeks after the care package had commenced. We found care staff were required to monitor specific areas of concern for people, for example, food and drink intake or pressure areas. Care records did not always clearly reflect the monitoring that took place and what action was required by staff if concerns were identified.

We also found people were experiencing issues with the time at which they received their care visits. The provider confirmed they had an electronic call monitoring system in place for some areas in which they delivered care. However, they confirmed that at the time of the inspection this system had not been used to monitor the time at which care visits were completed. The provider and registered manager had not identified the concerns that were shared with us regarding the time at which people received their care visits. They had not developed effective systems to ensure people received their care visits at the time they needed them.

We found the provider and registered manager had not developed effective systems to manage complaints. Multiple people and their relatives told us they felt concerns passed to the office were not appropriately escalated. They told us effective systems to communicate with the office were not in place. One person said, "I have a problem with the office. They never, ever call me back". Another person told us, "The [care staff] are very caring. The office not so much". A third person told us, "The office staff lets them down". Staff also shared their concerns with us about this issue. People told us they communicated with their care staff as they felt this was easier than contacting the office. They also told us they received updates about the service but this was usually from care staff and not from the office or management. One relative told us, "Messages don't get passed on. I tell [our] carers myself because I know they will not get the message [from the office]". Another relative told us, "We are kept up to date with developments but it is usually word of mouth usually from carers". The registered manager and provider had not ensured that effective communication systems were in place with the office team. This meant people felt the quality of the service they received was impacted and that concerns passed on were not dealt with and responded to.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

People told us they were happy with the service they received from their care staff while they completed care visits. Despite the concerns raised by people about the timing of care visits and communication issues with the office, they were satisfied with the service overall. One person told us, "I would recommend [care staff] to other people. It is a good service". Staff we spoke with told us they received good support from the registered manager and provider. One member of staff told us the management team was, "Brilliant!". Another staff member told us, "[The registered manager] is wonderful". They also told us, "[The provider] is great. I know he's going to listen to me". A third staff member told us, "I know [management] are there if we need them".

We found the provider, registered manager and quality and compliance manager were all committed to developing the service and making any required improvements. We saw where they were aware of concerns and issues they were taken seriously and were investigated thoroughly. Where any action was required such as further training or disciplinary action this was taken. We also saw where areas of improvement had been highlighted in feedback surveys action was taken. For example, in early 2016 people said they did not know who the manager was so the registered manager arranged to make visits to people's home. During the inspection we were told most people knew who the manager was. We did however find the management team were not always aware of the issues and areas of improvement needed due to poor communication and ineffective quality assurance processes. They told us they would be reviewing their auditing and quality assurance processes immediately following the inspection to ensure they could make any required improvements as a matter of urgency.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager were not always submitting statutory notifications as required by law.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had not developed effective governance and quality assurance systems. They were not effectively identifying the areas of improvement required in the service.