Care Quality Commission

Carewatch Care Services Limited

Carewatch (Derby)

Inspection report

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Ratings

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

Overall summary

This inspection took place on 15 and 17 December 2015. The inspection was announced, and we gave the provider 48 hours' notice to ensure there was a manager available to assist with the inspection process.

Carewatch (Derby) provides personal care to adults living at home in Derbyshire. At the time of our inspection there were 124 people receiving care. People using the service have a range of needs, including physical disabilities and dementia. The service had 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive their care calls when they felt they should, and felt they were not always told when staff were running late. The provider was planning to a new system to address this, but this was not in place at the time of our inspection visit.

Medicine administration was not always recorded accurately. The monthly audit of medicine records picked up most errors in the records we viewed, but did not consistently identify where there were errors in recording.

Summary of findings

People told us they felt safely cared for. Staff had a good understanding of the risks involved in people's care. One person told us they felt this was not always the case. We brought this to the attention of the provider and the local authority so this could be investigated.

Staff recruitment practice and procedures ensured people were supported by staff who were suitable to work with vulnerable people. Staff received induction, ongoing training and regular supervision to ensure they had the skills the provider required to deliver care. Staff were knowledgeable about people's needs and preferences for care.

Consent to care was not consistently sought in line with the Mental Capacity Act 2005. Although staff understood what was required of them, some people did not have the necessary capacity assessments or best interest decisions documented as required by law.

People were supported by staff that treated them with dignity and respect. People felt staff cared for them and understood their care needs.

The provider did not always review care or seek people's views about their care service as often as they said they would. There was a complaints policy and procedure in place which people knew about, but they did not always feel their complaints were resolved well.

Everyone we spoke with was happy with the staff who supported them, but some people were not happy with communication from the service, specifically in relation to late care calls.

Staff felt well supported by the registered manager, who understood their duties and responsibilities.

The systems in place for auditing the quality of the service provided did not always identify issues. However, where issues were identified, we saw the provider made changes to the service to improve the quality of care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People told us staff did not always arrive on time for care calls. Medicines recording was not always completed accurately. Recruitment procedures showed checks were done to ensure new staff were suitable to support people.

Requires improvement

Is the service effective?
The service was not consistently effective.

The Mental Capacity Act 2005 was not always followed where people could not consent to an aspect of their care. Staff were knowledgeable about people's health and social care needs. Supervision and appraisal of staff was carried out to ensure that they met the standards of care expected by the provider.

Requires improvement

Is the service caring?
The service was caring.

People were treated with care, dignity and respect by staff who knew them well. People were involved in planning their care where they were able to do so. Staff understood and demonstrated the importance of promoting independence and treating people with dignity.

Good

Is the service responsive?
The service was not consistently responsive.

People's views on their care was not always sought as often as the provider said they should be. People knew how to make complaints but were not always confident this would lead to improvements in their service.

Requires improvement

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

There were procedures in place to monitor the quality of the service, but these were not always carried out. Audits of care provided did not always identify issues that needed addressing. Staff felt supported by their colleagues and the registered manager.

Requires improvement

Carewatch (Derby)

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 15 and 17 December 2015. The inspection was announced, and we gave the provider 48 hours' notice because the registered manager is often out of the office supporting staff. We needed to be sure that they would be in.

The inspection was carried out by 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.

We looked at all the information we had available about the service. This included notifications received by the Care Quality Commission (CQC) and the findings from our last inspection. A notification is information about important events which the service is required to send us by law. We contacted the local authority commissioning team, the local clinical commissioning group, and Healthwatch Derbyshire, who are an independent organisation representing people using health and social care services. No concerns were raised by them about the care and support people received.

We asked the provider to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

We spoke with seven people who used the service, five care staff, the registered manager and the regional director. We accessed a range of records, including six people's care records (including four medicine administration records) and four staff recruitment, training and supervision records.

Requires improvement

Is the service safe?

Our findings

Six of the people we spoke with told us staff did not always arrive on time, and they did not always know when staff were running late. One person said, "Once it was so late I had to ring the office and ask what time the carers would be coming," and another person said, "Last month they didn't turn up at all twice it happened so I have to call the office and get them to send someone around." A third person said, "It's the lateness that bothers me."

The provider was investing in a new system to enable staff to alert the office if they were running late. This would mean the office could then contact people to let them know. However, this system was not in place at the time of our inspection. This meant that, while some people were unhappy with receiving late care calls, the provider was seeking to remedy this. However, this demonstrated, at the time of the inspection, people were at risk of not receiving care at a time when they were supposed to.

The provider had a computer system to enable them to establish staffing rotas to meet people's assessed needs. This system allowed the registered manager to match people's needs and preferences to staff skills and availability. The registered manager was clear they could not always offer a service to new people if they did not have the staff available to provide care.

Not everyone who was supported needed assistance from staff with their medicines. Many people managed their own medicines or had relatives to support them with this. Although we did not look at the storage of medicines in people's own homes, we spoke with people and staff about this. People who were supported by staff to manage their medicines told us they were happy with the way staff did this.

We looked at records relating to medicines and spoke with staff about their understanding of best practice. Staff told us they received annual training in the safe management of medicines. One staff member said, "It gives me confidence and knowledge to do medication." There was a good level of detail in recording how people needed to be supported with medicines, and clarity around what staff were responsible for. For example, one person's medicines care plan had specific information about what the person could do for themselves and what staff were required to do. Staff we spoke with were knowledgeable about how the person needed to be supported, and clear about what the person was able to do for themselves.

Staff told us the medicine administration records (MAR) were checked regularly, and we saw these were audited every month. One staff member said, "The audit will pick up if there are errors, or a pattern to errors." The MAR audits we looked at did not always pick up any issues with medicines missed or not signed for. For example, one person's medicines administration records showed a prescribed cream had run out between 2 and 23 September 2015 with no record that the person had received a new prescription after this. However the MAR had one signature on 23 September and six entries saying "other." We spoke with the registered manager about this and they acknowledged it was unclear if the person had received their medicine as prescribed. The MAR audits did not always identify issues relating to errors in recording medicines administration. This meant we could not always be sure that people had received their medicines as prescribed.

People told us staff helped to keep them safe. One person said, "When they leave they make sure that the front door is locked and that I'm safe and well." Another person told us, "About 50% of the time" only one staff member assisted them out of bed, but they said they felt safe with this. The records we checked confirmed two staff were required to safely support the person with moving and transferring. We spoke with the registered manager about this, and they investigated the concern. We also raised the issue with the local authority who investigated the concern. Records showed that two staff members were present on the person's care calls.

Staff demonstrated a good understanding of how to keep people free from the risk of avoidable harm. Staff felt confident to raise concerns about people's care, and knew who to share their concerns with. One staff member told us they had needed to do this in the past. They had felt supported to speak up and felt their concerns were treated seriously.

All staff undertook training on safeguarding people during their induction and had annual refresher training. Two of the staff whose training records we looked at had not had safeguarding training within the last twelve months, but

Requires improvement

Is the service safe?

the registered manager provided evidence they were booked on the training within the month. The provider had clear policies in place to let staff know what action they should take if they felt a person was at risk of abuse.

People felt staff supported them in a way that minimised risks and encouraged independence. One person said, "The carers look after me very well, they keep me safe by being careful when they shower me, making sure that I don't stumble. They are careful not to hurt me and go at my pace." Staff were knowledgeable about how to reduce risks for people, and what to do if they were concerned about any aspect of people's care. One staff member said, "Risk assessments have come on in leaps and bounds – they're more detailed and able to help us identify risks." The provider had risk assessments in place for providing care and these were reviewed annually or more often if required. The records we looked at showed people's risks assessments were updated following any change to their support needs. This demonstrated the provider had procedures in place to identify risks to people receiving care and to put measures in place to reduce the likelihood of avoidable harm.

Staff knew what their responsibilities were in an emergency. One staff member told us how what action they would take if they found a person had fallen at home. Another staff member described a person who had regular falls and what action they had taken to ensure that the person received medical assistance. We also saw records which demonstrated staff recorded when people needed emergency medical assistance, what action they had taken, and how the provider had followed this up. The provider had a clear policy in place detailing what action staff were expected to take in an emergency, and had a plan in place to deal with events that could affect the service, like adverse weather. Staff knew about this and knew what was expected of them to ensure that people continued to received care.

The provider undertook pre-employment checks to ensure prospective staff were suitable to care for people in their own homes. This included checking references and disclosure and barring service (DBS) checks. All staff had a probationary period and there were policies and procedures in place for the provider to support staff to demonstrate they had the skills and values needed for the role. We saw evidence to show, where staff skills were not meeting the provider's standards disciplinary action was taken where this was felt necessary. This meant the provider had checks in place to ensure that people were supported by staff who were suitable to provide care.

Requires improvement

Is the service effective?

Our findings

People told us they were happy with the care that staff provided. One person said, "I'm happy with what they do for me but they do rush around a little," and another said, "They are very helpful." A third person commented, "They do my personal care very well and I'm happy with that."

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA .

Staff said they received training in the MCA and demonstrated they understood what the law required them to do if a person lacked the capacity to make a specific decision about their care. One staff member said they needed to check out why someone was refusing care and work with them, rather than just assuming the person lacked capacity. Another staff member was familiar with the need to assess capacity and the principles of best interest decision making. The staff training records we looked at supported this.

Consent to care was not always sought in line with legislation. The care records we looked at did not always have assessments of capacity or best interest decisions recorded where it was appropriate for this to be in place. For example, one person's care records indicated and staff confirmed they did not have the capacity to consent to many aspects of their care. However, there was no record of capacity assessments or best interest decisions. We also saw the same person's care plans had been signed for on their behalf by a relative. We spoke with the registered manager and regional director about this and saw the provider was taking steps to ensure this documentation was done correctly. However, at the time of our inspection, the provider did not consistently ensure capacity assessments and best interest decisions were documented or reviewed. This demonstrated that although staff understood the importance of seeking consent to care, the provider did not always fully follow the principles of the MCA.

Staff were knowledgeable about people's individual health and social care needs, and demonstrated they understood how to provide care and when to seek advice or support for people. One staff member described how and when they would seek advice from community health professionals, such as occupational therapists or speech and language therapists. Staff also spoke about preferring to support the same people, so people had consistent care from staff that had got to know them well. Evidence in the daily recording of care showed staff were communicating changes in care, people's experiences, and key observations of care provision to their colleagues involved in people's care.

Staff had induction training and shadowed experienced colleagues before being assessed to enable them to meet people's needs safely. One staff member said their induction had covered a range of topics, including moving and handling safely, medication management, and infection prevention and control. This meant staff were given training and were assessed before being allowed to provide care on their own.

Staff told us they had regular meetings with their manager where they could get feedback on their skills, and could raise any concerns about people's care. The records we looked at supported this. The provider carried out regular checks on staff skills to ensure they were delivering care in a safe way. For example, an observation of care highlighted a member of staff had not been wearing any protective equipment whilst carrying out personal care. Evidence showed the provider had raised this with staff member and taken appropriate action.

The provider arranged ongoing training for staff to improve their skills, and staff had regular supervision meetings with their line manager to ensure they had the skills needed to provide care to people. Staff undertook annual refresher training covering a range of care skills the provider felt essential to their role. This included health and safety, nutrition and hydration, dementia awareness and first aid. Staff received additional training if they requested it, or if a person had specific needs. One staff member described training they had to support a person who needed stoma care and their training record confirmed they had undertaken training at a local hospital.

Requires improvement

Is the service effective?

People who received support to maintain a balanced diet told us they were happy with the assistance staff provided. One person said, "They then help me get dressed and go to the kitchen where they give me my breakfast. Meanwhile they are making my lunch and a flask of hot tea for the rest of the day. They make sure that I have enough to keep me going until tea time." Another person said, "They make sure I have drinks and food for the day so I don't get hungry or thirsty."

One person's records indicated how food and drinks needed to be prepared in a specific way to reduce the risk of choking. Their care plan had information from a speech and language therapist on how to do this. Staff were knowledgeable about how to prepare the person's food and drinks, and were able to tell us about the guidelines they followed, which were supported by the evidence in the person's file.

The people we spoke with told us they or their relatives had responsibility for arranging access to healthcare services. Staff told us community health professionals were good at communicating with them when people's health needs changed.

Staff felt they were able to support people to maintain better health if they had consistent staffing. One staff member said, "I like to try to keep continuity of care – it's better for noticing signs in people if they're poorly." Staff felt, and we saw, people's care plans were sufficiently detailed for them to be able to provide consistent care and to recognise when people's needs had changed.

One person's records demonstrated staff had identified they had problems swallowing, and had referred the person to a speech and language therapist for support. The same person's records also showed us staff were monitoring the person for signs of a potential chest infection, and staff had contacted a GP when they had concerns. This assured us that people were supported to maintain good health and, where necessary, were supported to access healthcare services.

Good

Is the service caring?

Our findings

People were treated with dignity and respect by staff who provided care.. One person said, “They treat me with respect and listen to me as they do their jobs.” Another person commented, “The carers are lovely to me.” People also felt staff were polite and supported them in a caring way. Staff we spoke with spoke about the people they supported in a kind and compassionate manner, and were knowledgeable about people’s wishes in relation to their care.

People were supported to make their own choices about care, and felt involved in planning their care. One person said, “They will only do the parts that I can’t reach which keep my independency,” and another person said, “I’m a very independent person and I only want the carers to do what I can’t on that particular day.”

Staff understood the importance of supporting people to be as independent as possible. One staff member said, “I need to promote [people’s] independence.” They were able to describe different ways of supporting people in a respectful and dignified way, for example, by providing care that suited people’s preferences, and by explaining to people what they were doing. Another staff member described how they supported a person with dementia, and said, “We always talk clearly with [person] about what we want to do and take our time. This keeps [person] calm.”

Most people’s care plans had detailed information about their preferences and routines. Where it was difficult for people to express their views, staff sought information from family members, where this was appropriate, about the person’s views on the care offered.

Staff told us they tried to offer people as much choice as possible to enable people to have the care they wanted. One staff member said they always needed to, “respect their [peoples’] routines, wishes and preferences.”

Staff demonstrated they understood how to protect peoples’ right to confidentiality, and were aware of how information should be shared appropriately. For example, by being aware of what information should be written in people’s daily care records, particularly where other people, such as relatives, might have access to these. One staff member told us, “I don’t talk about clients to anyone else except colleagues on a need to know basis. I will talk with families if the person wants us to and gives permission.”

People were treated with dignity and respect by staff when providing personal care. One person said, “All the doors and curtains are closed to protect my privacy and dignity,” and another said, “They provide me with personal care and they do this with my privacy in mind by closing the curtains and doors so no one can see me.” A third person described how staff chatted with them whilst providing care in a way which was, “very dignified.” Where people expressed a preference for male or female staff, or for specific staff, the service tried to provide this where possible.

Staff demonstrated an awareness of peoples’ preferences and this was supported by the evidence we saw in care records. Supervision and observations of care carried out by the provider showed dignity, respect, privacy and maintaining people’s independence were discussed and demonstrated by staff. This meant people received care in a way that was dignified and respected their personal preferences.

Requires improvement

Is the service responsive?

Our findings

People told us the care they received was generally as they liked it to be. However, one person expressed the view that they would be able to do more things themselves if staff had more time to spend with them. For example, "I like to undress my top part but carers want to do it for me because I'm a bit slow in doing it, but they need to get away to the next call. We only have 20 minutes to complete all the things that need doing so it's difficult for them to watch me doing what I can." This person clarified, "They are good carers but they don't have the time to go at my pace because they are running late. Again it's not their fault they have so much to do in the little time they have." Staff told us it was sometimes difficult to get all of the care tasks completed on a visit in the time they were allotted. The registered manager said when they reviewed people's needs they would discuss whether care could be provided properly in the time allocated to each person.

The care plans we looked at did not always contain relevant information about people's needs and preferences for care. Records showed the provider had identified what people's support needs were and how they liked staff to support them. For example, one person's records had detailed information about how they liked to be supported to wash themselves, including which cloths or sponges to use, and what toiletries they preferred. However, we identified one person, whose care records said had difficulty communicating, did not have any guidance for staff on how to ensure effective communication. Staff who knew the person well were able to describe in detail how the person communicated, and best to communicate with them, but acknowledged there was no written guidance. This meant there was a risk that new staff would encounter problems with understanding the person or being understood. We spoke with the registered manager about this and received assurance that this information would be added to the person's care plan. This demonstrated that people's care plans did not always contain enough information for staff to provide care effectively.

The provider had a system in place to review people's care, but evidence showed this was not happening as regularly as the policy said. Staff told us that people's care plans were reviewed every six months or more often if needed. Staff said in between the six month reviews, people and their families (where this was appropriate) were contacted by staff to check their support package still met their needs. The registered manager told us people's care was reviewed every six months, plus telephone contact in between this, and there was a full annual review of all of their support. They also said there were sometimes delays in doing this, and we saw evidence staff had tried to contact people or their relatives, where this was appropriate, to seek feedback. The registered manager said when they reviewed people's needs they would discuss whether care could be provided properly in the time allotted to each person. Where it was felt that the person needed a longer care call, the provider would ask the funders of care to reassess the person's needs. However, two of the people whose records we viewed had not had this opportunity for gaps of up to 13 months. The provider was unable to demonstrate that their system worked to provide them with more regular feedback about people's experience of care. Overall, this meant reviews of people's care were not done as often as they should have been, so there was a risk that issues about care would not be highlighted in a timely manner.

People knew how to raise concerns and make a complaint, but not everyone was confident this would result in action being taken. One person said, "If I have any concerns or want to complain I'd talk to the carers or the office." However, one person commented, "I have any concerns or needed to complain I would call the office but I'm not confident anything would be done," and another said, "I have complained many times but nothing changes so what's the point." Staff knew about the provider's complaints policy and procedure, and knew what information to give to people who wished to use this.

The provider had a complaints policy and procedure in place, which recorded the nature of the complaint, what action was taken and who had responsibility for this. For example, one person had an issue with the time of their care calls. Records showed the person's care calls were changed in accordance with their preference, and the registered manager sought feedback from the person afterwards. Information from daily care records and phone calls to the office about issues were audited monthly to enable the provider to see where people were having issues with the quality of their care package. The provider also looked at complaints on a monthly basis to see whether there were any themes they needed to take action to improve. This demonstrated the provider listened to

Requires improvement

Is the service responsive?

people's complaints and took action as a result, but the feedback we received from people told us their experience of raising issues was not always managed in the way they wished.

People did not specifically recall being asked for their views about the service, but told us they felt able to tell staff what they were happy with and what they would like to change.

Requires improvement

Is the service well-led?

Our findings

Although people were happy with the support they received from staff, they were not always happy with the communication from the office, particularly if staff were running late. One person said, "They are often late and nobody tells me what's going on." Another person said, "Nobody has the decency to let me know that they are going to be late." A third person commented, "When the carers are running late I'm never told I just have to wait for them to turn up." We did not see any evidence on our inspection that the service was aware of this issue, and the provider was not aware of any comments or complaints from people using the service. The provider had plans to improve the service, specifically in relation to letting people know if their care calls were going to be late. The provider was in the process of implementing a more responsive system to keep track of where staff were. This meant the provider would be able to let people know quicker if staff were going to be late, and the system would also help establish if people's care calls were long enough to meet their needs.

Staff told us they felt supported by their colleagues and by the registered manager. They felt able to raise concerns about care or suggest improvements to the service. One staff member described the registered manager as, "Very approachable." Another said, "I can ring [registered manager] any time; she is very supportive. If you've got a problem she will take the time to listen." Staff participated in regular team meetings where they felt able to share ideas and concerns relating to the service. Not all the staff we spoke with were aware of the team meetings, but described having regular contact with their supervisors and management to enable them to raise issues. The provider also communicated changes to the service or highlighted issues relating to care via a regular staff newsletter. We also saw that the provider openly displayed a large number of letter and cards from people using the service. This enabled staff to receive feedback from people using the service.

The provider had systems in place to review and audit the care offered to people. Audits did not always identify issues relating to people's care. For example, the monthly audits of medicine administration records were carried out, but did not always identify that there were errors.

The provider's system to review people's care did not happen as regularly as the provider's policy said. However, the provider sent people questionnaires about their experience of the service: 10% of people receiving care got a questionnaire every month. The provider analysed the feedback from people and we could see what action had been taken as a result.

People did not always feel that their concerns or complaints would be acted on, which meant there were opportunities that were missed for reviewing people's care needs and views, and using them to improve their service.

All staff were provided with a handbook clearly outlining their duties and responsibilities. The handbook directed staff to more detailed policies kept in the office, and this meant staff had easily accessible information about all aspects of their role.

The registered manager understood their duties and responsibilities in relation to the requirements of the service's registration with the Care Quality Commission, and felt well supported by the provider to undertake their role. We saw that the regional director frequently visited to provide support to the registered manager and staff in monitoring the quality of the service. The registered manager was undertaking a diploma in management, which demonstrated they recognised the need for continuing professional development.

Staff and the registered manager were proud of achieving a Peer Award in 2015, for nurturing talent (people and performance). The Peer Awards celebrate innovative initiatives that are making a difference within organisations, within their local communities, nationally and internationally. Based around sharing good practice these awards are judged openly and democratically online by the participants themselves.