Care Quality Commission

Drake Family Care Services Limited

Carewatch (Wessex)

Inspection report

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Ratings

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

Overall summary

This inspection took place on 9, 11 and 12 March 2015. We told the provider several days before our visit that we would be coming. Carewatch (Wessex) provides personal care services to people in their own homes. At the time of our inspection there were approximately 250 people who received support with personal care. 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 legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Staff sought people's consent to care and support and respected people's choices; however, formal processes and systems needed to be followed more consistently to ensure the service operated within relevant legislation and guidelines at all times. People received care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities effectively. People were supported to have sufficient to eat and drink, to access appropriate healthcare services and to receive ongoing healthcare support.

Summary of findings

People's care and health needs were responded to effectively. The service had appropriate systems in place to learn from any concerns and complaints raised by people or their representatives.

People were supported by staff who were trained to recognise different forms of abuse and respond appropriately to safeguarding concerns. There were sufficient numbers of suitable staff working to keep people safe and meet their needs in a timely manner. The service had effective systems in place for the safe management of medicines.

People and relatives we spoke with all told us the staff were caring. People's privacy and dignity were respected and promoted, and they were involved in making decisions about their own care.

The provider and manager had created a culture that was person-centred, open and supportive. Staff felt valued by the provider and manager, who were readily accessible to them, which in turn helped to encourage staff to provide a consistent quality of service. The service had appropriate quality assurance systems in place, which helped to identify necessary improvements and to maintain the quality of the care provided.

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?

Good

The service was safe. People were supported by staff who were trained to respond appropriately to safeguarding concerns, and there were sufficient numbers of suitable staff working to keep people safe and meet their needs effectively and in a timely manner.

People and their relatives felt safe and confident with staff and that care was provided safely.

Risks specific to people using the service were managed effectively, which helped to ensure people's safety.

The service had effective systems in place for the safe management of medicines, which protected people from risks associated with medicines.

Is the service effective?

Requires improvement

The service was not entirely effective in all key areas. Formal processes were not always followed consistently to ensure the service operated within relevant legislation concerning mental capacity and consent at all times.

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

People were supported to have sufficient to eat and drink, to access appropriate healthcare services and to receive ongoing healthcare support.

Is the service caring?

Good

The service was caring. People told us the staff were caring, and staff spoke warmly and knowledgeably about the people in their care.

People's privacy and dignity were respected and promoted, and they were involved in making decisions about their own care.

Is the service responsive?

Good

The service was responsive. People received personalised care that was responsive to their needs.

The service had appropriate systems in place to learn from any concerns and complaints raised by people or their representatives. People were listened to and felt that their concerns were taken seriously.

Is the service well-led?

Good

The service was well-led. The provider and manager had created a culture that was person-centred, open, inclusive and empowering.

Staff felt valued by the provider and managers, which in turn helped encourage them to provide a consistent quality of service.

Summary of findings

The service had appropriate quality assurance systems in place, which helped to identify necessary improvements and to maintain the quality of the care and support people received.

Carewatch (Wessex)

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 9, 11 and 12 March 2015. We told the provider several days before our visit that we would be coming. We did this because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be available. The inspection was carried out by two inspectors and an 'expert by experience'.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). The Provider Information Return (PIR) is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, which included the provider information return and notifications they are required by law to make to us.

During our inspection we went to the provider's main office. We spoke with the provider, the registered manager and another senior manager, and with eight other staff while at the office. We visited and spoke with five people who used the service and their relatives. After the inspection visit we undertook phone calls to 15 care workers, 18 people who used the service and the relatives of four people who used the service.

We reviewed the care records of nine people who used the service, 11 staff files, and eight people's medicine administration records. We also looked at other records relating to the management of the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe and confident with staff and that care was provided safely. One person told us, "I feel very confident and safe with them [the carers]." Another person told us, "They [the carers] are very polite. They always call out as they come in, so I know it's them." A person's relative told us the staff were "all very nice people, very polite and kind. I have no worries and neither does my [relative]." Another person's relative told us, "I feel very safe when staff are here. I trust them completely and often go out and leave them here on their own with my [relative]".

People were supported by staff who were trained to recognise different forms of abuse and discrimination, and respond appropriately to safeguarding concerns. Policies and procedures for staff whistleblowing and safeguarding people from abuse were in place. A whistle-blower is a member of staff who reports wrongdoing in the place where they work. Staff were able to access an in-house whistle-blower service provided independently through the umbrella organisation. The service worked according to agreed local safeguarding vulnerable adult protocols. Staff were able to define discrimination, and also to give examples of different types of abuse and of potentially abusive situations. Staff told us they believed the service's managers would deal effectively with any safeguarding issues, but they were prepared to go outside of the service and speak to agencies such as the Police and Local Authority if necessary, in order to ensure safeguarding concerns were addressed. One member of staff told us, "If I thought abuse of any kind was taking place I wouldn't hesitate to speak up."

People and their relatives told us they thought there were sufficient numbers of suitable staff working for the service to meet their needs effectively and in a timely manner. Nobody we spoke with identified issues related to missed visits, and many that we spoke with told us that on the whole, staff arrived promptly within a 15 minute leeway. Most of the people we spoke with said that staff never appeared rushed or cut short visits. One person told us, "They're never rushed. It's the other way round, they arrive on time and leave late because I keep them chatting!" Another said the carers "give you plenty of time, you never feel rushed. They [the carers] always take their time, I've never felt rushed. They're very patient with me.' Another told us, "they always stay for the full time, they never rush off.'

Staff records showed background and employment reference checks were carried out during the recruitment of all staff. We also verified that staff undertook appropriate role-specific inductions. New staff went out shadowing and were monitored by senior staff, and had a further interview conducted by the manager after three months' probation. The provider's checks and induction process helped to ensure people were kept safe and that staff were suitable to carry out the responsibilities of their individual roles.

About a third of the staff we spoke with raised concerns in relation to the service's staffing level. For example, one member of staff told us they thought the service was "short of staff across the board, especially at weekends." Another told us, "We always need more staff." A number of staff told us that staffing pressures meant they were not allocated sufficient time to travel between people. One member of staff told us, "We always need more travelling time. Our roads are country roads and are dangerous and narrow. The [managers] don't seem to think of that." Another member of staff told us, "I have strong complaints about that [travel time]; it's often non-existent. We are not paid for travel time. We only get paid for care hours. It's not safe, we rush to get to people and that's not right."

We discussed staffing with the manager, who assured us "We can only take on as much work as we have staff." They told us the provider was very supportive and that they were able to recruit as many staff as they wanted in order to deliver the service. However, they also acknowledged that "Recruitment has been difficult recently." Upon speaking with people who used the service we found no evidence that staffing levels impacted on the safety or quality of the care people received; however, lack of sufficient travel time did potentially increase pressure and the perceived level of risk for some staff.

Risks specific to people using the service were managed effectively, which helped to ensure people's safety. Care plans contained risk assessments for moving and handling, skin care, food and drink, the environment and medicines. Records contained appropriate detail and were easy to follow. For example, skin pressure area risk assessments explained why there was a concern, the control measures to be taken by staff and what action was to be taken in the

Good

Is the service safe?

event of skin issues occurring. The plan also gave clear instructions on what to do in the event of a member of staff noticing skin redness occurring. This demonstrated to us that staff had access to appropriate information regarding the support and management of tissue viability concerns. Another person had a plan in place to deal with potentially challenging behaviour. The plan described what may happen and how staff should deal with the situation as it occurred. The plan was easy to understand and follow, and meant staff had access to information that would help them deal with challenging behaviour in a safe and effective manner.

People benefited from effective systems related to the management of medicines. Staff records showed that staff who supported people with medicines had received appropriate training, and their practice was regularly observed and monitored in the field. Staff spoken with were able to give explanations of the correct practice and procedures for the prompting and administration of medicines. They were also able to explain to us about 'covert medicines' and 'homely remedies', and knew correct procedures for disposal of unused or refused medicines. We checked previously completed medication administration records (MARs) and found there were a number of gaps on charts from one of the service's six regional sub-teams. Senior staff investigated these gaps while we were on-site, and confirmed that the gaps were either when staff had simply failed to record properly when the person had actually had their medicine, or when the person hadn't actually been scheduled to receive a visit but, again, staff had not recorded that on the MAR properly. We were told the supervisor for this area had left recently; and although senior management were unaware of the extent of the problem with the MAR charts, another field care supervisor had already identified the problem. Senior management's response was swift and robust, and staff who had not been filling out the charts correctly were identified and booked on to medicines management retraining. We reviewed returned MAR charts from another of the sub-teams and found they had been recorded appropriately. There were no gaps and, where applicable, relevant codes had been used.

Requires improvement

Is the service effective?

Our findings

Staff sought people's consent to care and support and respected people's choices; however, formal processes and systems needed to be followed more consistently to ensure the service operated within relevant legislation and guidelines at all times.

We saw evidence of good practice in relation to mental capacity and consent. All of the people we spoke with told us they got to make choices concerning their care and support, and that staff sought their consent and respected their choices as a matter of course in carrying out their duties. We also saw records of formal 'best interests' decision making processes being followed in relation to decisions affecting people who lacked mental capacity to make decisions for themselves.

However, the Mental Capacity Act 2005 (MCA) requires care providers to follow clear procedures in relation to people who lack capacity to consent to their care and treatment. This includes ensuring mental capacity assessments are carried out for specific decisions. These should be followed by formal 'best interests' decision making processes for each person found not to have capacity to consent to their own care.

People's care plans contained insufficient evidence to confirm whether the person themselves consented or was unable to give their consent to all the care and treatment they received. In some care plans, for example, a general 'Service User Consent Form' had been signed by a family member indicating, in effect, that they had given consent to the package of care on behalf of the person using the service. The MCA states that a person is to be assumed to have mental capacity to make decisions for themselves, unless they have been assessed and judged to lack mental capacity to make those specific decisions. When a person is judged to lack mental capacity, then a formal decision making process should be followed and recorded to demonstrate that a decision has been reached which is in the person's 'best interest'. In the absence of a mental capacity assessment and subsequent best interests decision-making process, people using the service should have been assumed to have mental capacity to give consent to their own package of care.

Conversely, one person's care plan had been signed throughout by the person themselves, indicating that they gave consent to their own care package. However, their care plan also recorded that they had dementia and would forget what they had and hadn't done; this person's mental capacity to consent to their own care plan and package had not been assessed. The provider could not demonstrate they had acted in all instances either in accordance with people's wishes or, when they lacked mental capacity, that the care people received was in their best interest.

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. All of the people who used the services and their relatives who we spoke to were positive about the staff, and confirmed they delivered care and support effectively. For example, one person's relative told us, "My [relative] has to be moved with a hoist. They've all been trained and I've never worried that they don't know how to move my [relative]." The majority of staff's training was delivered in-house, by senior staff who had appropriate training qualifications. We reviewed the service's staff training records, which confirmed all staff received regular training in topics such as safeguarding vulnerable adults, fire safety, first aid, moving and handling, infection control and falls awareness.

In addition to mandatory training, staff also received trained in specialist subjects so they could meet people's specific and individual needs effectively. This included training in conditions such as diabetes, dementia, Parkinson's disease and Huntington's disease. When necessary, staff received training in palliative or 'end of life' care. Staff were encouraged to take job-related vocational qualifications, which furthered their own development. One member of staff told us, "There is always plenty of training. We only have to ask and it's arranged for us. They [the managers] are good like that." Another member of staff said, "We are always coming in for training and updates." Staff were led by a pro-active management team who encouraged and enabled continual professional development. That in turn meant people were cared for by a qualified staff team who were appropriately trained to carry out their duties effectively.

Where it was a part of the care package, people were supported to eat and drink according to their dietary requirements. One of the people we spoke with told us how staff "make me a lovely breakfast." Staff told us about support they provided to people with a range of different

Is the service effective?

dietary needs. This included people with diabetes and also people who required specific textured foods in order to support safe swallowing. Staff were able to give a clear explanation of the support they provided, which was specific and appropriate to meeting individuals' needs. For example, one member of staff told us how they supported a person who required a soft diet, following a 'choke plan' in the person's care plan and using a machine to pulp the person's food. They had also received training from the district nurse, so they were able to meet the person's specific dietary needs effectively.

People were supported to access appropriate healthcare services and to receive ongoing healthcare support. Care records showed that healthcare professionals were brought in to assist with meeting people's specific needs as and when required. People's daily care notes contained record of the involvement of healthcare professionals, such as district nurses and GPs. People gave us examples of how the service's staff recommended the involvement of other health and social care professionals as necessary to help meet people's changing needs. For example, one person's relative told us staff "told me I needed to ask social services for a pressure cushion because my [relative] sits a lot, and for a walk in shower because they can't get into the bath any more." Staff gave us examples of how they had got support from nurses, including tissues viability and district, and GPs in order to meet people care needs. They also told us they had a positive working relationship with other healthcare professionals. For example, one told us, "if I want to know anything I just ask them [district nurse]. We all get on really well and they are so helpful."

Good

Is the service caring?

Our findings

All of the people and relatives we talked with spoke positively about the service's staff and the care they provided. One person told us, "They're all very kind, very careful. I like them all." Another person told us, 'I couldn't wish for better" One said, "They're absolutely fantastic, I can't praise these girls enough. I didn't look forward or want it [care] at the beginning, but now I look forward to it." Similarly, staff spoke warmly and knowledgeably about the people in their care. One member of staff, for example, told us about a person they supported who had dementia, and that they had done additional dementia training, "so I could help her more and understand the condition."

People gave us examples of how the service's staff were caring. One person said, "They're very gentle and kind. They always ask me if I want a cup of tea or coffee before they go." A relative told us, "They're all patient and kind. They talk to me too, not just my husband [the person using the service], and they ask me if I'm ok." Other people told us that staff showed they were caring because they always tried to do a little bit extra for them. One person told us, "They make me a nice cup of tea, even though they don't have to. I can make tea myself, but the ones they make for me always taste better."

Staff gave us examples of practical ways in which they supported people's dignity and privacy. For example, one member of staff told us how they "cover people when washing, close the door if they are in the loo or shower, shut the curtains when dressing." People confirmed to us that all staff respected their privacy and dignity as a matter of course. One person explained to us that staff "know I get a bit embarrassed, but they make it very comfortable." Staff also delivered care steadily, at each person's own preferred pace. A person explained that, "They know where everything is and they know that I can be a bit slow because of my [condition]. They really understand."

Staff supported people's independence. One member of staff, for example, told us "I always try not to take over and 'do' things for people." Another told us how they would "Try to get people to do things for themselves. Don't interfere if they can do something on their own. Be patient and let them take their time." Staff also supported people's choices regarding their own care. One person, for example, told us, "Sometimes I might want to vary something on a particular day and I'll talk to the carer, who's always fine and never minds." Another person said, "Let me give you an example. I love football and my carer tonight knows that. She usually comes at 7.45 pm but she's coming earlier tonight so I don't get interrupted, I'll be able to see it all from the beginning. Isn't that fantastic?"

People experienced care that was provided by staff who treated them with kindness, dignity and respect.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs.

We asked staff what they understood by 'personalised care' and their answers demonstrated a good understanding of individualised, person-specific care. One told us it was "Care that is planned around the person." One told us it was "Care for that one person and tailor made for their specific needs only. Another member of staff said it was "where the client chooses what they want, makes their own decisions [about their own care]."

All of the people we spoke to confirmed the care they received was as they wanted it and in line with their own needs and wishes. They gave examples of how they were able to make decisions about the care they received. For instance, people confirmed they were able to specify the gender of the staff who worked with them and that this choice was always respected.

Care plans contained appropriate detail focused on meeting people's fundamental health and care needs. Care plans included assessments of need and risks, and key information such as medical history and medicines requirements, contact details for next of kin, allergies, nutritional information, communication needs, and skincare and mobility support needs. Personalised support plans gave detailed information about what duties were to be carried out by staff at each visit such as personal care, application of creams and lotions and what clothes people liked to wear each day.

Staff told us that they notified field care supervisors immediately if they identified a change in a person's needs, and that care plans and care packages could then be amended to respond to that change. The care plans we looked at had been regularly and recently reviewed by senior staff, which indicated they were being kept up to date.

People told us they had been involved in planning their own care, and that the care they received was in line with their own wishes. Some people were not fully aware of what their care plan set out, as either it had been discussed with Carewatch by a relative, or the person could not remember the detail. However, all people knew broadly what care they should be getting and when, and how long carers should come for. One person told us, "Someone came from the [Carewatch] office and we discussed what I wanted. They made suggestions and it's gone from there.'" Another person told us, "The agency came and went through the care plan with me at the beginning. They wrote it up and asked me if I was happy with it, which I was."

The service had appropriate systems in place to learn from any concerns and complaints raised by people or their representatives. Most of the people we spoke to said they had not had to make a complaint. All said they would feel able to complain to the manager or supervisor, or that a relative would be able to on their behalf. One person told us, "I've never had to [complain]. I would feel able to speak to one of the managers. I know them all by now." Another person told us, "There's never been a problem. The numbers are in the folder and [a senior member of staff] comes to see me sometimes. If I had a problem, I'd tell her, it wouldn't be hard." Two people told us about complaints they had raised previously in relation to their relatives' care, and the response from managers had been swift and addressed the issues in full. The service's complaints log contained a small number of complaints from people and relatives about communication, visit times and specific instances of care practice. The log recorded a detailed and timely response from the manager in response to complaints, including a record of the steps taken to investigate and resolve the complaints, then formal sign-off by the provider once resolved. People were listened to and any concerns or complaints they raised were answered properly.

Good

Is the service well-led?

Our findings

The provider and manager had created a culture that was person-centred, open, inclusive and empowering. People who used the service and their relatives told us that the provider and manager had created a positive atmosphere and culture at the service. One person told us, "It must be [well-led]. They seem to choose the carers very well. I'm wholly satisfied." Another said, "I think it is [well-led]. The manager is very particular." And a third person told us, "It's well run, very efficient and always works well."

People said that there was no difference in the quality or efficiency of care between weekends and weekdays. One person told us, "it doesn't seem to make any difference, I've not had any problem on a Saturday." Another said, "Weekends are never a problem, the carers who come are just as good."

People told us that if they ever raised issues with the service's managers they were dealt with quickly and effectively. One person told us, "I have no doubt they would sort problems out. They've been very efficient so far, I'm very pleased with them." Another person told us, "I'm confident that they listen, there's never been a problem."

Staff told us they had opportunities to raise any concerns or issues with management, through supervision and staff meetings. The majority of staff told us they could freely raise issues or concerns with senior managers, and that they felt there was an open and honest culture in place. A small number of staff raised issues with morale following recent team changes, but most of the staff spoken with told us they thought their managers were supportive and responsive and that it was a good organisation to work for. For example, one member of staff told us how senior managers had been particularly supportive of a colleague following the death of a person using the service, and that "They do try to look after the staff here." Another member of staff told us their managers were "Very professional, very helpful." Another told us they were "excellent employers, I can't speak highly enough of them." Staff felt valued, which in turn helped inspire them to provide a quality service.

The service had quality assurance systems in place, to identify necessary improvements and to maintain the quality of the care provided. A comprehensive annual audit was carried out through the umbrella organisation, which looked at areas such as records, staff training, health and safety and safeguarding. The latest annual audit had been carried out in February 2015 and the results were overwhelmingly positive. However, the audit had flagged up a number of areas where improvements were needed or issues needed to be addressed, and the findings were similar to our own findings at this inspection. For example, the internal audit highlighted a possible issue in relation to accuracy and completeness of medication administration records (MARs). It was recommended that 'MAR and log sheet audits need to be very robust, with clear evidence of actions to be carried out and recorded on the relevant staff files.' We looked through a quantity of recent MAR charts and identified a number of gaps on returned MARs. These were all from just one of the service's six areas and indicated a localised issue. The manager acknowledged our findings and assured us that they would be tightening up the process for auditing MARs. They also gave an assurance that all staff concerned would be required to retrain in order to ensure the mistakes did not reoccur. The overall standard of service provided indicated that the quality assurance processes the provider had in place were effective.

People who used the service and their relatives were enabled to provide feedback as part of the quality assurance process, through annual service user surveys. Most of the people and relatives we spoke to said they had been telephoned by the office or been asked to complete a survey about the service. One person told us, "I've occasionally had forms to complete, which are very thorough." Another said, "We get a form every six months or so, in fact I had one recently. They're very thorough, they ask about the carers and if I'm happy with my care." Other people told us that office staff called them periodically to find out if they were happy with the service or had any issues.