

Juniper Care Limited

Caremark (Enfield)

Inspection report

1 Chase Side Crescent
Enfield
Middlesex
EN2 0JA

Tel: 02036681551

Date of inspection visit:
19 May 2017
22 May 2017

Date of publication:
19 July 2017

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 19 and 22 May 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service. At the time of the inspection Caremark (Enfield) provided domiciliary care and support for 37 people in their own home. The service worked primarily with older people living with dementia and people with sensory and physical impairment.

At our last inspection on 30 March and 1 April 2016, we identified breaches of regulations 9, 11 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to, care plans not being person centred; a lack of information and understanding of the Mental Capacity Act (MCA) and inadequate risk assessments that failed to address people's personal risks. At this inspection we found that the provider had addressed the breaches regarding person centred care planning and the MCA. However, the provider had not adequately addressed the breach around risk assessments.

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 and has the legal responsibility for meeting the requirements of law; as does the provider. The registered manager was present during the inspection.

Risk assessments did not provide staff with guidance on how to mitigate people's individual personal risks. Risks had not been clearly identified and it was difficult to see what people's risks were. Information contained within risk assessments was often the same on all risk assessments and failed to ensure that staff were aware of how to mitigate people's individual risks.

People received their medicines safely and on time. The service had employed a medicines supervisor that audited medicines on a monthly basis and addressed any issues found. Staff received regular medicines training and competency observations.

The service operated safe staff recruitment procedures and ensured that all staff were suitable for the role before beginning any care work.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff did not receive regular supervision. However, the registered manager had identified this issue and a system was in the process of being put in place to address this. Staff had received an annual appraisal. Staff told us that they felt supported by the registered manager and senior staff.

Staff received a comprehensive induction when starting work including relevant training and shadowing more experienced members of staff before being able to work alone. Staff were provided with on-going

regular training to support them in their role.

People were involved in planning their care and had regular reviews to gain their opinion on how things were. Staff knew people well and people and relatives felt that they were treated with dignity and respect.

Care plans were person centred and included information on how people wanted their care to be delivered as well as their likes and dislikes.

The service carried out regular monitoring visits on staff to ensure that people were receiving good quality care and support.

People and relatives were provided with information on how to make a complaint.

Staff and people knew the registered manager well and felt that he was responsive to their needs.

Staff meetings were not being held which would provide staff with a forum to be able to meet up and share ideas and concerns. However, this had been recognised and staff meetings were being booked.

At this inspection we found a continued breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to address some of the concerns we found during this inspection. We will publish what action we have taken at a later date. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe. People had new risk assessments. However, risk assessments failed to provide staff with adequate guidance on how to mitigate risks for people in a person centred way.

The provider followed safe staff recruitment practices.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

People were supported to have their medicines safely. Staff had received training about medicines management. The service completed regular competency checks to ensure that staff were following the correct procedures for assisting people to take their medicines.

People received a continuity of care and usually had the same staff visiting them. Staff were on time and stayed the correct amount of time with people.

Is the service effective?

Good ●

The service was effective. Staff received annual appraisals that looked at their progress and performance.

Staff did not receive regular supervision to enable them to effectively carry out their role. However, this had been identified and was being addressed by the registered manager.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and how this impacted on the care that they provided.

People were supported to have enough to eat and drink so that their dietary needs were met.

Is the service caring?

Good ●

The service was caring. People were supported and staff knew people well and understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People were encouraged to have input into their care and were involved in planning their care.

Is the service responsive?

Good 

The service was responsive. People's care was person centred and planned in collaboration with them.

The service completed regular reviews of people's care.

Staff were knowledgeable about individual support needs, their interests and preferences.

The service completed spot check monitoring visits of staff to ensure appropriate and safe care was being delivered.

People knew how to make a complaint. There was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement 

The service was not always well led. Whilst risk assessments had been completed the registered manager had not audited them to ensure that they were fit for purpose.

Staff meetings were not taking place. However this had been identified and staff meetings booked.

There was good staff morale and guidance from the registered manager and senior staff members.

The service had a positive open culture that encouraged learning. Staff felt supported by management to carry out their role effectively.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

Caremark (Enfield)

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 19 and 22 May 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by one inspector.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at action plans the service had provided to us following the last inspection, nine care records and risk assessments, eight staff files, 10 medicines records and other documented information related to the management of the service. We spoke with the registered manager and three staff.

Following the inspection, we spoke with three people who used the service, three people's relatives and three more staff members. Where people were unable to communicate with us, we spoke with their relatives.

Is the service safe?

Our findings

At our last inspection we found that people's personal risks were not always being assessed. At this inspection we found that the provider had not adequately addressed this issue. The service had created new risk assessment forms which were more narrative rather than a tick box format. However, these were confusing and were not clear on what people's personal risks were. Where people had an identified risk, this had been taken from the company risk assessment guidance and cut copied and pasted without identifying the individual risk. For example, where a person had been identified as being at risk of falls, the section that asked 'what are the risks' noted, 'slipping, tripping, falling, major injury, serious harm, burglary, serious danger / harm, fire'. The risk that a specific individual had was not clear. This was the same for all risk assessments looked at.

Risk assessment forms had a section called, 'How the risk is reduced'. Information contained within this was generic and failed to address people's personal risks or provide staff with any guidance on how to mitigate the known risks. This information was cut, copied and pasted across all people's risk assessments that we looked at.

We spoke with the registered manager about this issue. The registered manager told us that the service had been concentrating on other breaches that had been found at the last inspection but accepted that current risk assessments were not fit for purpose.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People that were able to speak with us told us that they felt safe. People said, "Yes, I'm perfectly safe" and "Oh yes, very safe. I have excellent care." Two relatives commented, "Yes absolutely safe. No qualms about that" and "Yes, absolutely [safe]. He would let us know if he felt he wasn't safe."

At our last inspection we found that the service was not completing audits on people's medicines to identify and address any issues. Since our last inspection the service had employed a medicines supervisor. The medicines supervisor oversaw all people's medicines, carried out audits and addressed any issues that were found regarding medicines.

Medicines were administered in people's homes and staff completed and returned Medicine Administration Records (MAR) to the office each month. MAR's are documents that staff sign to say that they have administered people's medicines. We looked at 10 MAR charts for April 2017. There were numerous omissions in signing for medicines that had been administered. However, these had been identified by the auditing process. For each omission there was a form and an investigation and the outcome had been noted. In all cases the medicine had been administered and this had been documented in people's daily notes.

Where people were receiving 'as needed medicines', these were clearly documented on the MAR's. As

needed medicines are medicines that are prescribed to people and given when necessary. This can include medicines that help people when they become anxious, aid constipation or inhalers for breathing difficulties.

Care plans documented how people wanted to receive their medicines. The medicines supervisor told us, "Absolutely care plans say how the customer would like their medication. For example, on a small plate with their cup of tea. It tells staff what to do."

Records showed that staff received six monthly spot checks by the medicines supervisor to ensure a continual check on staff member's competency to administer medicines.

The service had safeguarding policy that staff had access to. Records showed that staff were trained in safeguarding during their induction and had received this training prior to being able to deliver care. Staff were able to explain how they would keep people safe and understood how to report it if they thought people were at risk of harm. Staff were able to explain different types of abuse and how people may present if they were suffering abuse. A staff member told us that safeguarding was, "Making sure that people you are looking after are safe. It's about reporting abuse such as neglect. I would report it to one of my supervisors and if necessary take it further such as the Care Quality Commission (CQC)." Another staff member gave us an example of what safeguarding was and said, "If, for example, I go to visit as service user and notice that their leg is bleeding I should call the company any report it or if very bad I should call an ambulance. If I do not and I leave [without doing anything] this would be neglect. Safeguarding is about abuse. Neglect is a form of abuse."

Staff understood what whistle blowing was and how to report concerns if they needed to. Whistle blowing is where staff are able to make any concerns known to an organisation external to their company, such as the local authority and CQC, without fear of recrimination.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks, such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. Where staff members required a visa to work in the UK, this was documented and a system was in place to remind the registered manager when these documents needed to be re-checked. This minimised the risk of people being cared for by staff who were inappropriate for the role.

Staff told us and rotas for March and April 2017 showed that staff were provided with adequate travel time in between care visits. Staff said that they felt that they had enough time at care visits to complete all the tasks necessary. One staff member told us, "Most calls I have are 30 or 45 minutes so I have enough time." People that we spoke with commented that they always had regular carers, one person had had the same carers for five years. Another person told us, "It's the same woman coming every time. She is very good and knows what she is doing." People also said that carers were on time and stayed the full amount of time that they were supposed to. One person commented, "One of them [staff] in particular, you could tell the time by when she rings on the doorbell. They're very good on time. If they're going to be late, they call me. They definitely stay for how long they're supposed to." Another person said, "They always wear their uniforms and identification cards even though I know them." Relatives were also positive on the continuity of care that people received and said that staff were always on time.

The service documented accidents and incidents. Incidents documented since our last inspection, had been investigated and an outcome recorded. The registered manager used these incidents and an opportunity to learn and where necessary, change processes to ensure a good quality of care.

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last inspection we found that the service was not adhering to the principles of the MCA. Staff had understood their responsibilities in relation to meeting the requirements of the MCA. However, the service had not assessed people's capacity and there were no records of best interests meetings where people may have lacked capacity. At this inspection we found that the provider had addressed this issue. People's capacity had been documented at the front of their care plans. Where people were unable to be involved in planning their care, relatives had been consulted and this was referred to on people's care records. People and relatives had signed their care plans. Staff had received training in the MCA and records showed that new staff received this training during their induction.

A senior care worker said, "On our initial assessment we actually ask [about people's capacity]. Are they able to communicate their agreement, can they tell us what we have discussed and understand the care that is being spoken about and can they retain [the information]? Can they weigh all information given to them? If they can then they have capacity. If not they may have their relative involved and we may need a capacity assessment." Staff told us, "[MCA] is to protect and empower the clients to make decisions depending on their capacity. If I noticed a change in someone's ability to make a decision I would contact the office immediately."

At our last inspection we found that staff received regular supervisions. However, at this inspection, we found that staff were now not receiving regular supervisions. Records showed that for the majority of staff, their last supervision had been in April 2016. Staff told us that they felt supported by the registered manager but confirmed that they had not been receiving supervision.

We spoke with the registered manager about this issue. The registered manager told us that it had been a challenging year and they were identifying issues that needed to be addressed. The registered manager said that he was aware that staff supervision needed to be completed. A system was being put in place that ensured staff would receive four supervisions a year, one of which being their annual appraisal. The new system had been implemented and records showed that all staff had received an annual appraisal since

March 2017. Appraisals looked at how staff felt they were doing in their role, their progress to date and if they required any training to be able to carry out their role more effectively. The registered manager told us that following the annual appraisals being completed they were now booking staff supervisions.

Staff training records showed when staff had completed training and when it needed to be renewed. All staff had received training which the service considered to be mandatory, such as manual handling, safeguarding, Mental Capacity Act 2005 and health and safety. Staff also told us that the service provided regular training and annual updates for mandatory subjects. The registered manager said that the service was looking at providing specialist training around working with people living with dementia and this would be provided to all staff.

Staff had a comprehensive induction when they started to work to ensure that they understood people's needs prior to working alone. Induction included three days of training in the office, including mandatory training such as manual handling, MCA, medicines administration and safeguarding. Following the office based training staff shadowed more experienced staff for a period of time, between one and three weeks depending on their previous experience, before being able to work alone. One staff member said, "My induction was good. It was about the company, policies and procedures and the clients we work with. I shadowed for about a week before being allowed to work alone."

The service provided light meal preparation for people where this was required. This was often heating food up for people or making a snack such as sandwiches. One person commented on an annual survey feedback form that, 'Lunch is always put on the table with care and flair. Looks good as well'. Another person told us that they received a cooked meal every Wednesday and said, "The girl that comes does my ironing whilst keeping an eye on the cooking. It's the only home cooked meal I get all week as I usually have microwave meals. I really look forward to it." Where people required support with meal preparation or encouragement to eat care plans documented people's like and dislikes around food.

People and staff told us that the service did not attend healthcare appointments with people and that this was generally managed by the family. However, the registered manager told us, "Where identified. It's ad-hoc and not built into the programme but they [people or relatives] will phone up and request support if need be."

Is the service caring?

Our findings

People and relatives were positive about the caring attitude of the staff. People said, "She [staff member] understands what I want. We work together" and "They [staff] are caring in their words and actions." A relative said, "The care itself is wonderful. Staff are fantastic." Another relative told us, "Mum's a chatter so they always have a good chat."

People told us that staff knew them well. Care records had a section with people's personal histories, likes and dislikes. Staff were able to tell us in detail what people they worked with liked and enjoyed. One person said, "I see her [staff] so often, she knows all about me and we always have a chat."

At our last inspection we found that it was not documented that people were involved in planning their care. At this inspection we found that the provider had addressed this issue. People and relatives had signed their care plans. People were involved in planning their care and felt that the service listened to their needs and preferences. One person said, "They listened to everything I said, and they do it." A relative told us, "We were involved all the way through. From start to finish." Another relative said, "When they came to assess [relative] they asked about everything. Even down to the colour of flannel that she liked to use for her face."

Staff had a good understanding of what dignity and respect meant to the people they were working with. Staff told us, "Treating someone how I would like to be treated. Focusing on what they want from the service. For example, medication. I would discuss with them how they would like their medication stored, if they are happy to have it in a cupboard as they may be quite private about it. It's about having the conversation and respecting their individual needs." Another staff member said, "If I am doing personal care, I make sure that my client is covered when we are going to the bathroom. Make sure curtains and doors are closed." All people that we spoke with said that they were treated with respect and their dignity maintained by staff. A relative said, "[Relative] is a very proud man and suddenly lost a lot of dignity and they [staff] respect that and work with him to make him feel good."

Staff told us that, where possible, they encouraged people to do things for themselves. A person said, "They [staff] are always encouraging me." People were encouraged to maintain as much independence as possible.

Staff understood the importance of providing choice to people. One staff member said, "We have a conversation with them. For example, lunch. I ask what they want, if they are able to come to the kitchen and have a look to decide, they do. If not I take choices to them and they can decide." One person said, "They don't do anything without giving me a choice of how and what I want."

Staff understood the importance of respecting cultural, religious and sexual diversity. People's faith was noted in their care plan and staff were aware if there were any specific requirements regarding people's faith or culture. A staff member said, "I respect everyone, regardless of their religion or sexual orientation. It's the care that's the focus."

Is the service responsive?

Our findings

At our last inspection we found that care plans were not person centred and did not include details of people's likes and dislikes. Information contained within care plans was often very brief, consisting of only a few lines. Information from people's initial needs assessments that were completed and detailed at the point of referral had not always been transferred into the care plan. At this inspection we found that the provider had addressed this issue.

All people's care plans had been reviewed and re-written since our last inspection. Care plans were now person centred and contained information around how people wanted their care to be delivered as well as people's personal preferences. People had been consulted and their wishes documented. For example, one person's preference around their food stated, 'I would like my main meal for my lunch. Please ask me what I would like. On a Friday I would like fish and chips from the chip shop. I would like snacks left for me on my table. Biscuits, crisps, fresh drinks'. During our inspection we observed a conversation between the registered manager and carer and were made aware that this person had received their fish and chips as it was a Friday.

Where people required personal care, care plans documented how the person wanted to receive their personal care and what staff should do. For example, a strip-wash in their bedroom or a full shower. It was also documented what type of shower gel or soap people preferred.

At our last inspection we found that the service was completing three monthly reviews of people's care. However, if there had been any changes, care plans were not updated following the reviews. At this inspection we found that the provider had addressed this issue. The service still completed reviews of people's care. However, this was now more robust. Where people received medicines and had complex needs reviews were every three months, anyone receiving personal care received six monthly reviews and anything else was yearly. Records showed that where any changes had been made, the care plans had been updated to reflect this. Relatives told us, "We've had a [senior staff member] come round and update [relatives] care plan. We've had to make a couple of changes and they've been very flexible" and "Yes, they do reviews and we get an updated version of the care plan."

The service completed monitoring visits to check on staff and ensure that they were delivering appropriate care. Records showed that monitoring visits were conducted every two months. Monitoring visits looked at things like how staff interacted with people, ensuring that people were treated with dignity and respect and that staff wore their uniforms and name badges. Where issues were identified these were followed up immediately with the staff member. Staff were not informed when monitoring visits would be taking place although people's consent was asked before the monitoring visit going ahead.

The service did not have an electronic monitoring system in place. This is a system where staff log in and out of their care visits and enables a service to monitor any missed visits. The registered manager told us that missed visits were monitored by the on-call system and people calling the office to inform them that a staff member had not arrived. Since our last inspection there had been eight missed visits. The registered

manager told us that for each missed visit, the staff member would be called into the office for a meeting and appropriate action taken depending on the situation.

People and relatives were provided with information on how to make a complaint when they began using the service. People and relatives said that they knew how to make a complaint and felt comfortable raising any issues if they needed to. There had been no complaints since our last inspection. A relative told us, "When we have had issues, they're on the ball. They keep in communication with us and go out of their way to make sure we're informed."

There were thank you cards expressing people's gratitude at the care provided. One thank you card said, "Thank you for everything you did for [friend]. Without your excellent support as well as patience she would not have been able to stay in her own home. We, her friends, admire and respect all that you did for her."

Is the service well-led?

Our findings

Staff were positive about the registered manager and said that they felt supported. Staff told us, "He's [the registered manager] very approachable. He will always find time if there's a problem, he will address it" and "I like the [registered manager] he's very down to earth and supportive. Will always listen to what you have to say." People and relatives said, "The manager is very good. They're all good there. They keep the lines of communication open" and "Oh, I know the manager. He's pretty good."

Following our last inspection and finding that medicines were not being audited the registered manager had employed a medicines supervisor. Medicines audits were completed weekly and reviewed by the registered manager. Records showed that where actions needed to be taken the registered manager ensured that these were completed.

Audits were completed around staff training and staff recruitment. Where issues were identified, these were addressed by the registered manager.

Risk assessments were not being audited to ensure that they were fit for purpose and provided staff with adequate guidance on mitigating any known risks. There were no other audits being completed. However, the registered manager had ensured that all care plans had been reviewed and an action plan following the last inspection was still in place.

At our last inspection we found that the registered manager held regular staff meetings. However, at this inspection we found that regular staff meetings were not taking place. Staff that we spoke with confirmed that there had been no staff meetings and one staff member said, "No, we haven't had any staff meetings recently." We raised this issue with the registered manager who told us that there had been a staff meeting held on 20 February 2017 but this had not been documented.

The registered manager held management meetings on a regular basis with senior members of staff. However, these were not documented. The registered manager told us, "I do an agenda and take notes. It is done informally." The registered manager told us that he had identified this as an issue and had put a plan in place to book and record regular staff and management meetings. We observed that these had been booked.

The registered manager completed a weekly newsletter for staff that included any information regarding the company, information about training and general news. One staff member said, "When they give us our rota for the week they send a little newsletter. It's nice."

The service had recently completed an annual survey in April 2017 and was in the process of collating the feedback received from people, relatives and healthcare professionals. Comments from people were positive and included, "We are very happy with the level of care my husband receives", "I like the fact that when a carer cannot come or a different one has to, I am always informed" and 'I look forward to their visits.' The registered manager told us that when all responses had been received these would be analysed and the

results sent out to people and relatives. The service used the surveys to gain people's feedback and where necessary look at any areas that may need to be addressed.

The service operated an on-call system for any emergencies out of hours. This operated from 17:30 until 09:00 weekdays and at weekends. People and relative that we spoke with were aware of the on-call system and said that if they used it they always received a response.