Claire Meade Care Limited

Caremark (Bradford)

Inspection report

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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

Our inspection of Caremark took place on 15, 16, 17, 18, 19 May 2017 and was announced. At our previous inspection in May 2016 we found the service in breach of Regulation regarding medicines management, quality assurance systems and failure to notify the Commission of safeguarding concerns. At this inspection, we found some improvements had been made and the service was no longer in breach regarding notifications. However, the service remained in breach regarding a lack of robust audit processes and we also found areas of concern remained relating to the safe management of medicines.

Caremark is a domiciliary care agency which provides care services to people in their own homes. At the time of our inspection 238 people were receiving a personal care service. The agency provides a service to adults and children, older people, people living with dementia, people with physical disabilities and people with sensory loss.

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 2008 and associated Regulations about how the service is run.

Most people who used the service felt safe with the care provided and we found there were systems in place to protect people from harm. Appropriate safeguarding notifications had been made. Staff had received safeguarding training and understood how to keep people safe.

Risk assessments and care plans were individualised and person centred. These were reviewed on a regular basis to ensure they contained accurate and up to date information. Staff we spoke with understood the care and support they provided to people and displayed a person centred and caring attitude to the people they supported.

There were policies and procedures in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivations of Liberty Safeguards (DoLS).

We found medicines were not always managed in a safe or proper way. In particular, we found discrepancies with documentation, namely between medicines administration records (MARs), daily records and information contained within people's care plans.

Sufficient staff were deployed with the relevant knowledge and training to support people's needs effectively. People were mostly supported by the same staff team and matched with staff from similar backgrounds to ensure wherever possible cultural needs were supported. Recruitment checks and systems were in place to ensure people employed by the service were safe to work with vulnerable adults. Staff received induction training, supervisions, observations and spot checks as well as annual appraisals. Staff meetings were in place and an annual satisfaction survey sent to all staff, with results analysed and actions

taken.

People's feedback on the service was regularly sought through care plan reviews, telephone checks, surveys and quality checks by management when they visited people's homes. Most people told us staff were reliable and treated them with kindness and compassion although some people said they were not always notified if a staff member was going to be late.

There was a robust complaints procedure in place which enabled people to raise any concerns or complaints about the care or support they received. The service investigated complaints thoroughly and documented actions and outcomes.

There was a quality assurance monitoring system in place that was designed to monitor and identify any shortfalls in service provision. Some improvements to systems had taken place since our last inspection. However, we found some quality audits remained insufficiently robust to identify areas requiring improvement, such as medicines management.

Most staff we spoke with praised and felt supported by the management team. However some people and their relatives told us they felt communication could be improved.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take in relation to this at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely.

Safeguarding procedures were in place and staff understood how to keep people safe.

Sufficient staff were deployed to care and support people safely. Staff were recruited safely to ensure they were suitable to support vulnerable people.

Is the service effective?

Good

The service was effective.

A training programme was in place. Staff told us this had provided them with the necessary skills to provided effective care and support.

Staff were effective in supporting people with their health care needs.

The service was working within the legal requirements of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People told us staff were caring and supported their care and support needs.

Staff knew people well and from our discussions we saw some good relationships had developed.

People's independence was supported as much as possible and people's choices were respected.

Is the service responsive?

Good

The service was responsive.

Care records were reflective of people's needs and contained person centred information.

People's needs were assessed prior to service commencement and regularly reviewed.

A robust complaints procedure was in place.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality audits were in place but the medicines audit had failed to identify issues found at inspection.

The management team were committed to making improvements to the service.

People's opinions of the service were sought through various methods including annual survey and telephone monitoring.

Caremark (Bradford)

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.

Our inspection of Caremark took place on 15, 16,18,19, 20 May 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service.

The inspection team consisted of two inspectors 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. The expert used on this occasion had experience of domiciliary care.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications we had received from the home. We contacted the local authority safeguarding and commissioning departments to get their views on the service. The service had completed a Provider Information Return (PIR) which is a document which tells us about the service, what it does well and improvements it plans to make. We received the PIR in a timely manner and took this into consideration when making our judgements.

We visited the Caremark office on 16 May 2017 and spoke with the registered manager, the deputy care manager and the operations manager. We looked at the way people's medicines were managed, looked at elements of 14 people's care records and viewed other records relating to the management of the service such as call logs, quality assurance audits, staff recruitment files and training records.

On 15, 16, 17 May 2017 we spoke on the telephone with 10 people who use the service and nine relatives. On 18 and 19 May 2017 we spoke with 14 care staff on the telephone.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in May 2016 we found medicines were not consistently managed in a safe and appropriate way. At this inspection we still found this was the case.

We identified some good medicine practice. Individual medicine agreements were in place which specific the level of support people required. People had a medicines profile in place which in many cases provided the required information on the medicines people were prescribed and the reasons why. However details were not always recorded as to whether medicines were contained within dossett boxes or their original packaging which would ensure safe administration. Some medicines administration records (MARs) were well completed which provided assurance that these medicines were given as prescribed.

We found other MARs were not always properly completed. Of particular concern was that documentation discrepancies which indicated unsafe practice, had not been identified by auditing systems to ensure they were promptly investigated to check whether people were safe. One person's MAR for March and April 2017 and their medicine pen picture showed they were prescribed a medicine to be given every other day. However, the MARs showed it was signed for daily. The deputy manager investigated this discrepancy and concluded the person had received their medicines as prescribed, with the MAR chart being incorrect, however this discrepancy should have been identified at the time by staff recording administration or the audit process.

The same person was also prescribed a medicine, but the MAR for March and April 2017 was blank. We raised this with the management team who checked and said that the family now gave this medicine. However there were no details this arrangement within the person's medication profile. This issue had also not been picked up by the audit of these MARs. This person was also prescribed paracetamol to be given four times a day. However on reviewing daily records of care for March/April 2017, the time between the teatime and evening visit was not appropriate and regularly around 2.5 hours between doses of paracetamol. This was the same as issue found at last inspection. It is important that medicines such as paracetamol are administered with a four hour gap to mitigate the risk of overdose. The provider told us they had identified this at the end of April 2017 and this practice no longer took place.

Another person was prescribed co-codamol to take four times a day. We saw they received two visits from staff at 10.30 and 17.00 where staff administered this tablet. However there was no documented information on how the person received the other two prescribed doses and how this could be done safely with appropriate gaps between administration.

Another person was prescribed a laxative which the MAR indicated should be given once a day. However this had been signed for as given twice a day by staff in February 2017. Following our inspection, the registered manager sent us information which confirmed the medicine was being administered correctly and the directions on the MAR had been printed incorrectly by the pharmacy. However this record had been audited and these issues had not been identified.

A person was prescribed a medicine which it was vital was taken consistently. The MAR chart showed it was not given in line with the prescribers instructions. Whilst the medicine was in a dossett box and we were therefore confident it had been given correctly, it had not been documented this way. The April MAR audit had indicated 'no concerns. All boxes filled in.' This showed the issues we found had not been identified at audit.

The administration of topical medicines such as prescribed creams was not always recorded in a consistent way. Some MARs contained details of topical medicines and records were appropriately kept and others had information contained in medication pen pictures and body maps. However one person whose daily records showed they required two different creams applying. They had no body chart or MAR in place, or information in the medication pen picture as to when either cream should be applied. From the detail recorded in their daily records we were unable to confirm which cream was applied at any given visit. This meant the record did not provide evidence the person was getting their medicines as prescribed.

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

People and their relatives told us they felt mostly safe with the care staff, although some commented about some care staff attitude. Comments included, "Yes", "Not with all of them. Some tend to patronise", "I do, yes", "Yes, I think so. ([Relative] has never complained," and, "No, sometimes if I don't want a wash they will comment. It could be that I'm exhausted if I've had a bad night."

Risk assessments were in place within care and support files demonstrating the individual risks to each person had been assessed. Risk assessments covered areas such the home environment, skin integrity and moving and handling and any specific assessments such as how to use the shower safely. These provided information to staff on how to deliver care safely.

Staffing levels appeared to be sufficient to keep people safe and people told us they usually received care and support visits by the same staff members, apart from weekends. Comments included, "It's usually the same two staff", "I usually see the same staff. They can vary. If they're on holiday, I get a stand-in but they are not strangers", "I see the same ones. They know what to do. Now and again you get different ones", "It's been better lately. We see the same ones in the week usually, but at weekends it can be anybody that comes and we have to tell them what to do. [Relative] needs the same person. [Relative] gets used to the same people, then they change and it's not good for [relative] and I know that they are still working (for the company)." The registered manager told us they were recruiting care staff to specifically cover weekend visits so people received care from the same team and three care staff were on call at weekends to cover sickness and holidays. Most staff told us they thought sufficient staff were deployed although others commented about being pressured to work extra shifts.

The service used an electronic call monitoring system which meant staff logged in and out of calls and this information was received by the office and a report was generated. This meant the service could promptly identify any missed calls and was a key safety net to ensure people were not left without care and support. We reviewed call logs and found missed calls were minimal.

We saw staff were allocated travel time in between visits and a 'catch up' period in the afternoon. Staff told us travel time was usually sufficient although some staff commented of difficulties arriving on time at peak traffic times or if their care visits were not close to each other. These concerns were also highlighted in responses to the recent staff survey.

Safeguarding procedures were in place and we saw appropriate referrals had been made to the local

authority and the Commission. Where referrals and notifications had been sent, we saw collated information documented at the front of the safeguarding file which gave an overview and meant analysis could be carried out. Staff had received safeguarding training and understood how to keep people safe. Accidents and incidents were well documented with details of the incident, actions and outcomes.

We saw on call arrangements were in place and a member of the management team held the 'out of hours' phone. Robust disciplinary procedures were in place where required.

Good

Is the service effective?

Our findings

We saw a training matrix in place which indicated what training staff had completed and where refresher training was required. Training was up to date or booked and included subjects such as moving and handling, first aid and safe administration of medicines. A local pharmacy delivered medication training and team leaders were being trained to offer moving and handling training. Other service specific training was given to staff in areas such as epilepsy, buccal midazolam administration and percutaneous endoscopic gastrostomy (PEG) feeding in order to support people in these areas. Staff told us the training was good and had equipped them with the necessary skills for their roles. A staff member commented about the training, "Always been excellent."

New starters attended a five day induction programme which included practical training and service policies and procedures. New care staff were enrolled on the Care Certificate to complete within the first 12 weeks of employment. The Care Certificate is a government recognised qualification designed to give staff the necessary skills to provide effective care and support. The registered manager told us staff were also encouraged to enrol on National Vocational Qualification (NVQ) training after two months' employment.

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. In the case of Domiciliary Care applications must be made to the Court of Protection. The service had not needed to make any applications to the Court of Protection. We found the service was working within the principles of the MCA and staff had an understanding of how these principals applied to their role and the care they provided.

Care plans considered people's capacity to consent to their care and treatment. Where people lacked capacity we saw relatives had been involved in decisions as part of a best interest process. We saw evidence independent mental capacity advocates (IMCAs) had been contacted to support people to make decisions for example around medicines administration.

People's needs were assessed prior to service commencement to ensure the service was able to fulfil their requirements. The registered manager told us they had refused or returned care packages where they were unable to fulfil people's needs. We also saw the service matched people and their care workers from the same backgrounds wherever possible since the service supported people with a wide range of cultural needs.

People's dietary needs were assessed and clear plans of care put in place to ensure staff supported people appropriately at mealtimes. This included people's dietary preferences, for example, whether they wanted

sugar in their tea and the type of cereal they preferred at breakfast time. This demonstrated a good person centred approach.

We saw one person's food and fluid intake was being monitored. We found these charts were being consistently completed and showed the person was regularly provided with food and drink with staff in line with their plan of care.

We saw the service responded to people's healthcare needs and involved the relevant health and social care professionals, such as GPs, district nurses, emergency services and social workers. For example, one staff member told us when they suspected a person had suffered a stroke, they contacted the emergency services and remained with the person and family until the ambulance arrived, notifying the 'on call' person at Caremark since this happened out of hours. One relative commented on how responsive the staff had been to their relative's healthcare needs and said, "[Relative] hasn't had any infection like urinary tract infections since Caremark took over."

Good

Is the service caring?

Our findings

Most people we spoke with were complementary about the care they received. Comments included, "For young people, they are really good. They always ask me if there is anything else they can do for me. They are fantastic", "They are very good and I don't have a problem. The girls are lovely", "They are fantastic (care staff). They make me comfortable, they are very respectful even when showering me. Even a young man has just the right approach; very caring. If I don't have a shower, they wash me. [Relative] says they ought to pay them double," and, "They are most caring and they get upset if I get upset. Yes, they cheer me up."

Relatives were also mostly complementary about the caring nature of the staff. Comments included, "They are exceptional, lovely, lovely girls. They are really, really exemplary. They won't let me help. They are all lovely", "They are patient; they have to explain and re-explain to [relative]," and, "They are all very kind," and, "I'm fussy but I get on with them (the care staff). They are really kind. I can't find fault with the carers." However, some relatives and people told us staff attitude was variable. Comments included, "They are good but especially the morning carers and [staff member]. Some are brilliant, some don't provide that touch. Some like [staff member] are brilliant. They hug [person] and stroke [person] and [person] loves that. It's the human touch; some don't have it," and, "It was [person's] birthday and some of the carers brought [person] flowers, chocolates and [staff member] brought her flowers, chocolates and a card, out of the blue! Some (care staff) are rigid; some need to be more flexible."

Staff we spoke with were able to tell us about people they supported and gave examples of their care and support needs as well as likes and dislikes. This showed us staff knew people well.

We asked staff how they ensured people's privacy and dignity was maintained. Answers provided us with assurances that people's privacy and dignity were maintained wherever possible, such as closing doors, curtains, asking other people to leave the room and ensuring private parts were covered when supporting with personal care.

Care plans were built around people's individual choices and preferences which showed the service valued ensuring people had choice and control over their lives. Daily records showed people were asked consent and their decisions and refusals of care respected. Where people were unable to speak for themselves or had no relatives to do so, we saw the service used independent mental capacity advocates (IMCAs) to speak on their behalf and in their best interests.

Information on people's backgrounds, likes, dislikes and preferences was included within care plans. This showed staff had taken the time to understand people and helped provide highly personalised care. People were also encouraged to be as independent as possible. For example, care plans focused on allowing the person to do as much for themselves in areas such as washing and dressing.

Race is one of the protected characteristics of the Equality Act 2010 which also includes; age, disability, gender, marital status, religion and sexual orientation. One care staff member told us how they had been requested to support a person whose first language was Spanish, since they were a fluent Spanish speaker,

so their care and support needs were effectively met. We also saw evidence of people's religion and race being respected, through allocating appropriate care staff who understood their culture. We saw no evidence to suggest anyone who used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

We reviewed care files and found people's needs were assessed prior to using the service. This was used to formulate a comprehensive care plan which contained step by step instructions of how staff should provide care and each visit. These contained defined goals and outcomes to help people achieve. Plans were detailed and person centred, with enough information for staff unfamiliar with the person's circumstances to deliver appropriate care. Preferences around how people preferred their drinks and the type of towels to use during personal care were recorded.

Daily records of care provided evidence care and support tasks were carried out in line with their plans of care. These contained an appropriate amount of information and evidenced people's social and emotional needs had been considered. A relative commented, "They carry out the care plan as I want them to and as agreed," and another said, "They do everything they should."

People's care and support was subject to regular review. We saw people were asked their opinions in relation to their care and changes made where appropriate to help ensure the service adapted to people's changing needs. For example, we saw one person had requested an early evening call and records we reviewed showed this had been actioned.

We reviewed daily records of care and saw calls mostly took place at an appropriate time each day and staff stayed the correct amount of time. This helped ensure people received an appropriate and unrushed service. In one person's records, we did identify that some evening and tea visits were close together which could reduce the effectiveness of the person's continence plan of care. For example, a teatime call had occurred at 17:02 and the evening call at 18:42.

Whilst call times were mostly consistent from day to day and care plans contained the length of each call, we identified that most records did not have an agreed call time to provide a formal agreement and help manage people's expectations. Most people told us staff arrived at an agreed time but others commented this did not always happen.

A complaints policy and a complaints file was in place. This included detailed information about the complaint, actions taken and outcomes, including correspondence and meetings with the complainant. The service had received 18 complaints in 2017 which we saw had been thoroughly investigated. We saw recent improvements had been made to the complaints file to include all relevant information and a synopsis sheet at the front to allow for analysis of trends.

Requires Improvement

Is the service well-led?

Our findings

Care files showed a range of quality checks were undertaken to ensure care was delivered safely and appropriately. This included spot visits to people's homes by care-coordinators, to check people were happy with care and support, that staff were on time, appropriately dressed and that all required documentation was in place. Telephone satisfaction surveys were also undertaken with people on a regular basis. Following these visits, action plans were generated and action taken to address any negative care experiences.

Staff were also subject to regular spot checks of their practice. Staff received checks on their competencies in a number of areas including medicines management, nutrition and hydration and moving and handling.

Documentation such as food charts, daily records and medicine administration records (MAR) were returned to the office on a regular basis. These were then audited to check their quality. We saw some of these checks were effective in identifying discrepancies, for example, flagging up to office staff if care staff had not recorded the time they entered/left a person's house. However, although the registered manager told us trends regarding accidents/incidents and safeguarding were analysed during the weekly management meetings, there was no documented evidence of an overarching analysis to look for themes and trends in order to drive improvements. The medicines audits in particular needed to be more robust as the issues we found during the inspection by reviewing MAR charts had not been picked up by the provider's own audits. This had also been identified as an issue at the last inspection.

This was a breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activity Regulations 2014.

During the inspection process we found the management team committed in their approach to delivering quality care and support. The office environment was relaxed and we noted issues were addressed in a professional manner. The management team kept up to date with best practice by attending events such as local provider meetings and events to keep updated about current legislation such as new guidelines for medicines management in domiciliary care settings.

People we spoke with gave mixed views on the management of the service with some saying communication could be improved, for example, if care staff were going to be late, or the effectiveness of the office response if they raised concerns. Comments included, "Communication is the worst thing", "We rang them when [person] was in hospital but they still sent the carers round for three days," and, "They all say 'we'll sort it out', but they never do, do they hell! They never listen to clients." However, other people commented, "I can't fault them. They got rid of a girl who wasn't up to scratch," and, "I've never complained; I'm lucky."

An annual satisfaction survey was sent to people who used the service and we saw out of 220 sent, 74 responses had been received. The results of these were mostly positive, with most saying they knew who the care manager was, how to contact them and that their service was well managed.

Most staff we spoke with were complementary about the management team and told us they felt able to approach them with any concerns. Comments included, "Whenever I've phoned they've been really helpful", "The management team are approachable", "[Registered manager] remembers you. She's definitely friendly and approachable. She's very much a people person", They're very, very good. I'm very supported by the office. If I've got a complaint they deal with it. They are so good for the people they're caring for. They really care. They are a really good company to work for," and, "The management team are flexible and support us." Most staff told us they would recommend the service. However, other staff were concerned about communication from the office with regards to rotas, updates and the attitude of some office staff.

We saw results from the annual staff survey which showed most staff were happy in their roles and felt supported. We saw areas for improvement highlighted with actions such as more introductions to clients and improved staff meetings. Staff meetings were held regularly and the registered manager told us of the improvements to these including introducing a bi-monthly area meeting where the registered manager or operations manager would be present. During meetings, discussions were held on a variety of topics including sickness, punctuality, communication, safeguarding, confidentiality and encouraging people's independence. We saw a monthly newsletter was circulated to staff which included topics on training, service updates, results of the recent customer survey and long service awards.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The proper and safe management of medicines; the recording of medicines was not always in line with current legislation and guidance. Regulation 12 (1)(2) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of robust audit systems in place to identify and respond where quality and/or safety were being compromised. Regulation 17 (1)(2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014