Carewatch Care Services Limited

Carewatch (Kirklees)

Inspection report

570 Wakefield Road
Waterloo
Huddersfield
West Yorkshire
HD5 8PU

Tel: 01484431143
Website: www.carewatch.co.uk

Date of inspection visit:
31 October 2016
04 November 2016

Date of publication:
02 December 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection of Carewatch (Kirklees) took place on 31 October 2016 and was announced. We previously inspected the service on 26 February 2014. The service was not in breach of the Health and Social Care Act 2008 regulations at that time.

Carewatch (Kirklees) is registered to provide personal care. Care and support was provided to approximately 120 people who lived in their own homes within the Huddersfield area.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe. Staff received safeguarding training and were aware of their responsibilities in keeping people safe from the risk of harm or abuse. Care plans contained generic and person specific risk assessments which recorded the steps staff should take to reduce the risk of harm to people and to themselves.

There were systems in place to reduce the risk of employing staff who may not be suited to caring for vulnerable people. People who used the service and staff told us calls were not missed and people usually received care and support from regular staff.

All staff received regular training in medicine awareness and we saw there had been recent improvements made to the observational assessment of staff's competency to administer people's medicines. There had also been changes to the medicine administration record to ensure relevant details for each prescribed medicine were recorded.

New staff received induction training and shadowed a more experienced member of staff when they commenced employment. Staff received regular refresher training and there was a program in place to ensure staff received ongoing supervision including a field based assessment of their skills.

Staff had received training in regards to the Mental Capacity Act 2005. Changes had recently been made to the organisations care planning documentation regarding capacity assessments and appointed lasting power of attorneys'. Care plans contained a customer consent form to enable people to consent to the package of care they received from Carewatch (Kirklees).

Everyone we spoke with told us staff were caring and kind. People told us staff treated them with respect and took steps to maintain their privacy. Staff were able to tell us about the actions they took to maintain people's dignity and ensure peoples private information was kept confidential.

People and staff told us care plans were in place and were reflective of people's needs. We found care plans were person centred and recorded a good level of detail about the person's needs and preferences. A record was maintained of the daily care and support staff provided to people and there was a system in place to enable office staff to know when care records needed to be reviewed and updated.

No-one we spoke with raised any concerns or complaints about the service, people told us if they had any issues, they would telephone the office to discuss the matter with a member of the office team. Feedback from staff and people who used the service was positive.

There was a system in place to assess and monitor the service provided to people. This included staff meetings, audits of records and feedback from people who used the service. The organisations head office provided Carewatch (Kirklees) with a monthly overview in regard to their performance in a number of key areas, including staff training and review of peoples care records.

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 told us they felt safe.

Recruitment procedures were thorough.

The management of medicines was safe.

Is the service effective?

Good

The service was effective.

Staff received induction and on-going training and supervision.

Staff respected people's right to make their own decisions regarding their daily lives.

People received support to eat and drink.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

People's privacy and dignity was respected.

Confidential information was not shared inappropriately.

Is the service responsive?

Good

The service was responsive.

People had care plans in place which were reflective of the care and support needs.

There was a system in place to ensure care plans were reviewed at regular intervals.

People knew how to raise a complaint.

Is the service well-led?

Good

The service was well led.

The office based staff were knowledgeable about the people they provided care for and the staff they employed.

There was a system in place to audit the quality of the service provided to people.

There were systems in place to seek feedback from people who used the service and from staff.

Carewatch (Kirklees)

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 31 October 2016 and was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure the registered manager would be available to meet with us. The inspection team consisted of two adult social care inspectors. We also visited Carewatch (Kirklees) office on 4 November, this visit was also announced.

Before the inspection we reviewed all the information we held about the service. We contacted Healthwatch to see if they had received any information about the provider. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We contacted the local authority safeguarding, commissioning and monitoring team and reviewed all the information regarding the service.

During our visit we spent time looking at nine people's care plans, we also looked at eight records relating to staff recruitment and training, and various documents relating to the service's quality assurance systems. We spoke with the registered manager, care co-ordinator and the quality officer. Following the inspection we spoke with six care staff on the telephone. We also spoke on the telephone with four people who used the service and nine relatives of people who used the service.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe. When we asked one person they said, "Safe, oh yes." Another person said, "Definitely." A relative responded, "Yes I think (person) is safe."

The registered manager and each of the staff we spoke with were clear about the different types of abuse, signs or changes in a person's behaviour which may indicate abuse and the action they should take in the event of having any concerns. One staff member said, "Any concerns, I would ring the office." Another staff member we spoke with said, "It's about protecting vulnerable people, being professional and protecting them from harm." The training matrix recorded all staff had completed training in safeguarding. This showed staff were aware of their responsibility in protecting people from the risk of harm or abuse.

Each of the care plans we reviewed contained a generic risk assessment regarding the person's home, for example, access, lighting, fire safety and pets. There was also an individual risk assessment relevant to the persons care and support needs. For example one of the care plans contained a risk assessment for skin integrity, falls and asthma. There was also a risk management plan in place which recorded the action staff were required to take to reduce the risk of harm to the person. For example one risk assessment recorded, 'when (person) is standing and walking, ensure they (staff) are immediately behind (person) in case they lose their balance'. Another person had a risk assessment in place pertinent to the safe use of bed safety rails to reduce the risk of them falling out of bed. Where people required the use of equipment to enable them to transfer from one place to another, for example, with a hoist, the documentation recorded details of the equipment and how it should be used. This included how the sling should be fitted and which loops should be used. This showed care and support was planned and delivered in a way that reduced risks to people's safety and welfare.

We asked the registered manager what they expected staff to do in the event the person they visited did not answer their door and staff were unable to gain access. They said staff were to telephone the office or 'on call' phone and seek advice, staff would be asked to check the garden, look through the persons windows or ask neighbours. They told us this had recently happened and as the person could not be located and they could not contact the person's family, they had notified the police who had attended the persons home and gained access. When we asked staff they echoed the actions the registered manager had said to us. This demonstrated staff knew what was expected of them in the event of a person not being located when they arrived for a scheduled call.

Staff we spoke with were also clear about what they should do in the event they attended a call and the person had fallen. One staff said, "I would check they were ok, I wouldn't move them and I would call 999. I would ring the office and they would notify the family. I'd stay with them until the ambulance got there." Another staff member told us this scenario had recently happened to them, they told us, 'The office was really supportive." This showed staff were aware of how to reduce the risk of further injury or harm in the event a person suffered a fall.

We asked two about the recruitment process. They told us they had attended for an interview and the

registered person had obtained references and a Disclosure and Barring Service check (DBS). We reviewed the recruitment files for eight staff and saw evidence of an application form, references and DBS. The registered manager told us new staff were not allowed into people's home until all pre-employment checks had been completed. This showed there was a system in place to reduce the risk of employing staff who may not be suitable to work with vulnerable people.

When we spoke with people who used the service, no one raised any concerns regarding missed or late calls or having numerous different staff attending to them. One person said, "The times can be up and down, but they have never missed." Another person said, "I have regular staff, they are occasionally late but I have never had a missed call." A relative said, "If they are late, they (staff) call us." Only one person made a negative comment, they said their relative had told them, "Occasionally they (staff) are out of the door before (person) is at the bottom of the stairs." Following the inspection we brought this to the attention of the care co-ordinator.

When we spoke with staff they also told us they usually provided support to a regular group of people. One staff member we spoke with said, "If we are late, they let the person know." They also told us how the office staff helped staff with delivering care to people in the event of staff sickness, they said, "They (office staff) go and do the work too, they don't just pile it on the care staff, they help out."

We asked the registered manager how they reduced the risk of late or missed calls. They told us the registered provider was implementing an electronic call monitoring system but it was not yet fully operational for all staff. They explained staff were being provided with a mobile phone which would enable them to electronically log in and out of a person's home, the office staff would then receive an automated alert in the event staff failed to attend for a scheduled call. This enabled office based staff to investigate the reason for this and take appropriate action to ensure a member of the staff attended to the person.

The care co-ordinator told us, "The majority of people have consistent staff." They showed us their electronic rota and call planner, we reviewed the calls for one person who received care and one staff member. This evidenced an effective system was in place to try and ensure people received care from a regular staff team. They also showed us how they were able to block a member of staff being allocated to a particular call, for example if the person did not want male staff attending their calls. This showed peoples personal preferences were taken into account, where possible, when staff rotas were planned.

One person we spoke with told us staff helped them with their medicines, they said, "They get them (medicines) out for me. They know what they are doing." When we spoke with staff they told us they received medicines training. One staff member said, "I have done training, also when I did my shadowing, there was a checklist about medicines, like the correct medicines at the right time." Another staff member said medicines training was refreshed by staff every year. The training matrix recorded all staff had completed training in medication awareness and we saw evidence of this in each of the staff files we looked at. This helped to ensure staff had up to date knowledge to support them to complete their job to the required standard.

The registered manager told us staffs competency to administer medicines was assessed when staff first commenced employment. However, they said a robust annual competency assessment had very recently been introduced. They explained they were unable to show us any which had yet been completed but they showed us a blank document, which included an observational and theoretical assessment. Regularly assessing staff competency helps to ensure staff have the appropriate knowledge and skills to reduce the risk of errors being made with people's medicines.

Some of the staff we spoke with also told us new medicine administration record (MAR) had recently been introduced. One staff member said, "There is a new MAR, we have just had training on them. We have to list each medicine now, date and sign it." When we spoke with the registered manager they told us improvements had been made to the MAR's following discussions with the local authority and other local care providers, the new MARs had been implemented from September 2016. We looked at the new MAR for one person and saw it recorded each individual medicine including the dose and details of when it should be administered.

These examples demonstrate the service was taking steps to improve the assessment of staff's ability to manage people's medicines and how the administration of people's medicines were recorded.

Good

Is the service effective?

Our findings

We asked some of the people we spoke with if staff had the skills to enable them to perform their role effectively. One relative said, "Yes, they all know how to use the hoist, they know what they are doing." Only one person we spoke with responded negatively, they said some of the staff lacked experience.

We spoke with three staff who had been recently employed. They told us they had completed induction training over a number of days at the office and felt the training had prepared them for the role, they said, "Yes, you get to know all the basics." Another said, "They teach you what to do and what not to do." When we reviewed staff files, for staff more recently employed we saw evidence they had completed a program of induction. We looked at the induction training book and saw the induction was completed over five days, covering a variety of topics which included the care certificate standards. These are a set of standards that social care and health workers adhere to in their daily working life. They are the new minimum standards that should be covered as part of the induction training of new care workers. The booklet was completed by staff during their induction and recorded their learning and understanding. Staff also told us they had shadowed a more experienced staff member when they had begun work with Carewatch (Kirklees). This showed new staff were supported in their role.

Staff all told us they received regular training which included practical training, for example, how to use moving and handling equipment. We reviewed the training matrix and saw this recorded individual staff names and the training they had completed, the matrix also highlighted where staff training needed to be updated. We saw training topics included, moving and handling, food safety, infection prevention and control and first aid awareness. Each of the staff files also contained evidence staff received regular training. An assessment of learning workbook was also completed by staff when they updated their training which recorded the subjects covered and evidenced staffs understanding of what they had been taught.

Staff also received on going supervision including a field based observation of their competency.
One member of staff told us someone from the office 'just turned up' to completed a spot check of their performance. Another staff member told us they felt supervisions and spot checks were useful, they said, "It is good for both parties, any problems, they (office staff) can sort it out for you." The registered manager told us staff received a minimum of 2 supervisions, an appraisal and a field based competency assessment each year. The care co-ordinator showed us a spreadsheet which detailed individual staff and the date of their most recent supervision, appraisal and field based competency assessment. This highlighted in amber, where these were needed to be completed in the coming weeks and highlighted in red where staff were overdue. This showed there was a system in place to ensure staff received regular management supervision to monitor their performance and development needs.

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. For this type of service any applications to deprive a person of their liberty must be made to the Court of Protection.

We saw from the training matrix, only two of the 47 staff listed had not yet completed MCA training. One of the staff we spoke with said, "It's if they can't make decisions, we help them, it's about what is right for them." Another member of staff said, "It's about the capacity of the individual, everybody can be different."

The organisation had recently made changes to the care planning documentation; this included a section entitled 'Making Decisions'. This recorded information regarding people's capacity and where appropriate, the persons' lasting power of attorney. We reviewed the care plan for one person who clearly lacked capacity to make decisions and consent to the delivery of their care package. We did not see any evidence of a capacity assessment or of best interest's decision making, although the care plan referred to a relative being the nominated lasting power of attorney. The registered manager also said they had not been provided with evidence the relative was an appointed power of attorney for the person. The quality officer told us the organisation did not complete capacity assessments and the organisation would refer the person back to the social worker in the event of any concerns. We discussed with them the need to ensure they could clearly evidence the organisation was acting within the requirements of the Mental Capacity Act. Following the inspection the registered manager emailed us evidence of a capacity assessment completed by the care co-ordinator regarding the person's capacity to consent to the delivery of their personal care.

Each of the care plans we reviewed contained a customer consent form. In one of the care plans, this was signed by the person's relative although we were unable to determine, from the care plan the reason for this. If a person lacks capacity to consent, another person should not sign a consent form on their behalf unless they have specific legal powers to do so, for example, health and welfare lasting powers of attorney. Although we also saw two other consent forms which had been signed by relatives, both forms recorded the reason why, for example, 'customer unable to sign'. This showed staff had recorded the reason for the person not signing the consent form themselves.

One person told us staff supported them with their meals, they said, "I tell them what I want, they are micro wave meals, and they (staff) heat it up for me." Where people required support to eat and drink, this was recorded in peoples care plans. For example one care plan detailed, 'I would like my carer to prepare my meals and drink.' This showed people were supported, where required, to eat and drink.

Each of the care plans we looked at recorded the contact details for the persons GP and other relevant healthcare professionals, for example, the district nurse or pharmacist. We spoke with one relative who told us staff had contacted the local district nursing service for their relative when they felt the person needed more specialised input. One of the care plans we reviewed detailed, 'carers to monitor my skin integrity at each pad change, any red marks or concerns should be reported to the district nursing team'. This showed people were supported to receive support from external healthcare professionals when required.

Good

Is the service caring?

Our findings

Without exception, people spoke positively about the staff who provided their care and support. Comments included, "The staff are very nice.", "I haven't had anyone I didn't like." And, "They (staff) are nice, kind and helpful." A relative said, "They (staff) follow (persons) guidelines of what they want. They respect what (person) says." Another relative told us about one particular member of staff who was "Nice, and very attentive." A member of staff told us, "We look after them like you would look after your own family."

In one of the care plans we reviewed we saw there had been an issue regarding the compatibility of staff for one person. The document recorded the action taken by the quality officer to address the situation, including the quality officer completing the initial call themselves with each new member of staff allocated to the call to ensure the person felt more comfortable. This showed the quality officer respected the person's preferences and had taken action to reduce their anxiety.

Peoples care plans had a section where a synopsis of their life history was recorded. This provides staff with a simple insight into a person's background and can enable staff to engage in meaningful conversations, encouraging social interaction and communication during the provision of peoples care and support.

We asked two people if staff maintained their dignity and treated them with respect, one said, "Yes they do." Another person said, "They are very kind, they cover me up." A relative told us, "(Person) has never said they feel embarrassed." Another relative said, "They (staff) have a laugh and a joke with (person) but they treat them with respect." One of the staff told us, "We close curtains, hold a towel in front of them. We talk to them and try to put them at ease." Care plans also recorded the steps staff should take to ensure people's privacy and dignity were respected. For example, 'speak clearly' and 'close doors and curtains'. This showed the organisation recognised the importance of treating people with dignity and respect.

People told us staff enabled them to do what they could for themselves. One person said, "They (staff) let me do what I can. I can do my top half and they help with what I can't do." One member of staff told us how they enabled one person to maintain their independence when preparing their lunch; they explained they worked with the person to prepare their snack together. People's care plan also recorded the tasks they could complete independently and where they needed staff support. For example, 'I am able to wash my own hands, face, chest and groin but require the carer to wash the rest of my body'. Staff were also able to tell us how they enabled people to make choices. One staff told us how they took a sample of clothes from a person's wardrobe who had limited visual ability. They explained how the person felt the clothes and made their choice of what they would like to wear. Another staff member said, "I ask them, what they want to wear or eat. What they want to watch on TV." Encouraging people to maintain independence and make choices for themselves can help in improving people's quality of life.

In each of the staff files we saw staff had signed to acknowledge the organisations confidentiality policy. We asked one staff member what they did to maintain people's confidentiality; they said they ensured they did not speak about other people who used the service in front of anyone else. The registered manager told us many of the documents staff needed regarding peoples care and support were now held on mobile phones,

provided for staff by the organisation. They explained a security PIN was required to access the information and after a short period of inactivity, the phone 'locked' again. This helps to reduce the risk of unauthorised access to people's confidential information.

Good

Is the service responsive?

Our findings

When we asked people if they had a care plan in their home, people told us they did. One person said, "Yes, and I think it has just been reviewed." A relative said, "Yes, we do." Another relative told us, "Yes, (name of quality officer) came out and met with us. They have put in place much of what we asked for. They have reviewed it (care plan), once that I am aware of." We also asked some of the staff we spoke with about peoples care plans, one staff member said, "Yes, everyone has a care plan and they are reflective of people's needs. If needs change, we tell the office and they change it (the care plan)."

The quality officer told us when the organisation accepted a new person's care package, they completed a welcome visit. This included going to meet the person, and, if required, their family too. They explained this helped them to gain the information they needed to draft the person's care plan. Having a care plan in place when a person's care package commences ensures staff have the information they need to meet the person's needs safely and effectively.

Each of the care plans we reviewed was well organised, relevant information was easy to locate and the details about peoples care needs was consistently recorded throughout their care plan. The care plans were person centred and detailed how the person wanted staff to deliver their care. For example, one plan recorded, 'I will decide if I want a strip wash or a shower.' Another care plan noted, 'Fill my tea to the brim'. Care plans also recorded how people communicated, for example, 'At times I may shout out, but not necessarily in the right context. I can hear and sometimes I may respond', and 'I will communicate through facial expressions.' Having this information ensures staff are aware of peoples individual methods of communication.

The care co-ordinator explained the organisation was in the process of linking people's computerised records to staffs mobile phones. The registered manager told us this would enable staff to access relevant information about the people they supported on their phones. They said this would be very beneficial in the event staff had to attend to a person they may not have supported before or if it had been some time since their last visit. This would help to ensure staff had up to date information about people's individual needs and preferences.

One of the staff we spoke with told us they recorded the care they had delivered each day in a log book kept in the person's home. However, they also told us how the organisation was moving towards staff electronically recording peoples care on mobile phones. We reviewed a random sample of daily records. They recorded the names of staff who attended the call, arrival and departure times as well as summary of the care and support provided to the individual. This enabled the organisation to check the quality of the service provided to people and to ensure the care delivered was in line with their care plan.

The quality officer told us care plans were reviewed every six months and a full assessment was completed every twelve months. They said the re-assessment was always completed with the person or their family. The registered manager told us that some people's reviews were currently behind schedule, this was as a result of a number of local authority contracted service users care packages being transferred to them in

recent weeks. The care co-ordinator showed us a spreadsheet which detailed when peoples reviews and re-assessments were due. We saw some people were highlighted in amber, where the review was imminent and others were highlighted in red to show the review was overdue. This meant that although some people's reviews had not been completed within the organisations preferred schedule, they had a system in place to ensure they were able to clearly identify and prioritise the work which needed to be done.

As part of the inspection we reviewed how the service managed complaints and concerns. People and their relatives told us, "If I have ever contacted the office, they have acted on it." And, "I have never had a reason to complain, but if I did, I would just phone the office." Another relative we spoke with told us if they rang the office to raise a concern, the relevant staff member always rang them back to talk to them. The registered manager said any formal complaints would be logged and dealt with in line with the organisations complaints policy. We saw where complaints were recorded, this included information about the nature of the complaint and the action take to address the issue. This showed there was an effective complaints system available. When we looked at the organisations compliments file we saw a letter from the local authority thanking the staff team for 'enabling service users to be successfully transferred from another service provider.'

Good

Is the service well-led?

Our findings

The registered manager had been employed at the service for approximately two years and had been the registered manager since December 2015. The registered manager, quality officer and care co-ordinator were all professional throughout the inspection, they were knowledgeable about people who used the service and the staff who worked with them. They each spoke of how they communicated on a daily basis to ensure relevant information was shared, recorded and acted upon appropriately. We asked the registered manager what they felt was good about the organisation, they said, "We genuinely care about our people."

Feedback from staff and people who used the service was positive. One staff member said of the registered manager, "She's ace." Other staff comments included; "It is a really good organisation.", "They are really friendly in the office. They are a good firm to work for." And, "If you ring the office about any issue, they ring you back." A relative said, "We are really satisfied." Another relative said, "They are really good."

The care co-ordinator showed us the organisations intranet system, they explained all relevant paperwork, policies and governance systems were held within this. In the event of any documents being updated or changed, the registered manager received an alert to notify them of this. They said this ensured paperwork used by the office staff was current and was consistent throughout the organisation. The care co-ordinator demonstrated the organisations governance management system including how accidents, incidents, complaints and safeguarding's were logged on the system. They also showed us the monthly performance indicators the office staff received each month from the organisations head office, these were in regard to compliance targets for a variety of topics including staff training and supervisions and service user feedback. This meant the office staff were able to see an overview of their performance in relation to a number of key areas.

Regular audits were completed to review the delivery of the service to people. This included assessments of staff performance, reviews of care plans and inspecting people's care records. We saw evidence of these audits during our visit to the service. For example, in one of the personnel files we reviewed we saw the care co-ordinator had written to a member of staff to request they bring a specific piece of documentation in to the office because 'we have recently been checking personnel files and have found the document does not appear or is out of date in your file'. This evidenced checks were made to ensure all relevant documentation relating to staffs employment was in place.

The registered manager said the office staff randomly selected a number of daily records and MAR's each month for auditing. Some of the records we reviewed had completed audit sheets, they recorded the date of the audit, any issues identified and the action taken. For example, one audit noted staff had failed to record the time they had left a call on three occasions; the auditor had recorded 'spoken to carer'. This showed records were checked to ensure they met the standards set by the organisation.

We asked people if the organisation asked them for feedback. One person told us they remembered completing a survey 'about four months ago'. A relative said, "They have been from the office to see if all is ok. I have had a visit and a call, it was to see if staff were doing their jobs." Another relative said, "(Quality

officer) called me when we started to use them to check we were all ok." This showed people were asked for their views about the quality of the service they received.

The quality officer told us staff meetings were held every couple of months, one of the staff we spoke with confirmed this and said minutes of the meetings were also sent out to staff. We saw minutes of staff meetings which had been held throughout the year. Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.