Carewatch Care Services Limited

Carewatch (Central London)

Inspection report

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Website: www.carewatch.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We conducted an inspection of Carewatch (Central London) on 19, 20, 21, 23 December 2016 and 5 January 2017. At this inspection a breach of regulations was found in relation to person centred care, dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, complaint handling, staffing and submitting notifications to the CQC. We issued warning notices in respect of the breaches relating to person centred care and safe care and treatment. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to these areas. We undertook this focused inspection to check that they had followed their plan in relation to the warning notices and other breaches of regulations to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Carewatch (Central London) on our website at www.cqc.org.uk.

Carewatch (Central London) provides care and support to people living in their own homes. There were 300 people using the service when we visited.

At the time of our inspection there was no registered manager at the service. The previous manager had left the service approximately two weeks prior to our inspection and a new manager had been recently appointed and was working at the service when we visited. They were in the process of submitting their application to be the registered manager to the CQC.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.

At our previous inspection we found care workers understood how to safeguard the people they supported. However, we identified three examples of safeguarding concerns that had either not been investigated or reported to the relevant local authority in a timely manner. At this inspection we found care workers still had a good understanding of how to safeguard people. We did not identify any safeguarding concerns that had not been investigated or reported.

At our previous inspection we found risk assessments and support plans contained some information for staff, but there were many examples of incomplete or inconsistent record keeping and therefore we could not be assured that people were protected from avoidable harm. At this inspection we found some progress had been made to ensure that care records contained enough information for care staff. However, there were still some examples of care records not containing enough detail about the risks to people's care.

At our previous inspection we found medicines were not accurately recorded when care workers administered them, so it was not possible to determine what medicines people had taken and when. At this inspection we found progress had been made to ensure accurate records were kept and senior staff were in the process of reviewing all MAR charts to ensure this was happening.

At our previous inspection we found care records contained limited information about people's healthcare needs and very little recorded information from healthcare professionals. At this inspection we found some progress had been made to ensure that care records contained appropriate information about people's health needs. However, there were still some examples of care records not containing enough detail about people's health needs.

At our previous inspection we found that staff demonstrated knowledge of their responsibilities under the Mental Capacity Act 2005. However, records did not always contain details of people's capacity and records were often not signed by the person using the service. Senior staff did not ascertain whether signatories to documentation had the legal authority to make decisions on people's behalf and therefore we could not be assured that people's rights were being protected. At this inspection we found some progress had been made to ensure that care was provided in accordance with people's valid consent. However, there were still some examples of care records not being signed by people using the service or of records not containing details about people's capacity.

At our previous inspection we found that appropriate numbers of staff were not always deployed to provide people with care. People requiring two care workers to attend to them did not always receive this support. People with moving and handling needs were sometimes hoisted by one person despite needing to be hoisted by two people for their safety and the safety of staff. At this inspection we found people who required two care workers were provided with this support.

At our previous inspection we found complaints were not investigated and responded to in a timely manner. At this inspection we found complaints were investigated and responded to in a timely manner.

At our previous inspection we found information was not reported to the Care Quality Commission (CQC) as required. We found evidence of five safeguarding incidents that were not reported in line with requirements. At this inspection we found that incidents were reported to the CQC as required.

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

We found some action had been taken to improve the safety of the service.

Some risk assessments were still under review and yet to be updated to ensure that they contained accurate and up to date information in relation to identifying and managing risks to people.

People requiring two care workers received this support when needed.

Medicine administration record (MAR) charts were completed appropriately. Senior staff were also reviewing these records to ensure this was happening.

Procedures were in place to protect people from abuse and action was taken to investigate and take appropriate action in relation to safeguarding concerns.

We have improved the rating for safe from inadequate to requires improvement as some improvements had been made. We will check if these improvements have been fully completed and sustained during our next planned comprehensive inspection.

Is the service effective?

Requires Improvement

We found some action had been taken to improve the effectiveness of the service.

Some care records were still under review and yet to be updated in relation to people's health needs.

Some action had been taken to ensure people were provided with support in accordance with their valid consent. However, there were still examples of some people being provided with care without having their capacity assessed to ensure this was provided in accordance with legal requirements.

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice

over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

We found some action had been taken to improve how responsive the service was. Complaints were investigated and responded to in a timely manner.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

We found some action had been taken to improve how well led the service was. Notifications were submitted to the CQC as required.

The service had an action plan in place to address the remaining issues in the service, but had not had sufficient time to address these.

We could not improve the rating for well led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Carewatch (Central London)

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. We undertook an unannounced focused inspection of Carewatch (Central London) on 8 and 9 June 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 19, 20, 21, 23 December 2016 and 5 January 2017 had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, effective, responsive and well led? This is because the service was not meeting some legal requirements.

The inspection team consisted of one inspector. The inspection was announced. We gave the provider 48 hours' notice of our inspection as we wanted to be sure that someone would be available.

Prior to the inspection we reviewed the information we held about the service. We also contacted representatives from the local authority.

During the inspection we spoke with ten people using the service and eight relatives. We spoke with the manager of the service, eight care staff and a Director who had overall responsibility for implementing the provider's action plan. We looked at a sample of 20 people's care records and records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found that people's care records were inconsistent, often contained errors and lacked detail. We saw numerous examples of risks not being fully considered where areas of risk had been identified.

At this inspection we reviewed 20 care records and found some care records had been improved. On referral to the service, a senior member of staff visited people in their homes and conducted a risk assessment on the safety of the home environment as well as various possible areas of support, including people's medical conditions and nutritional needs. This information was then incorporated into a care plan known as a 'needs assessment' which informed the care worker of the tasks that needed to be completed when supporting people as well as other relevant information. Where care records had been improved, we found comprehensive information recorded about the risks to people and how these were managed. For example, in one risk assessment related to a person's risk of falls we saw information about what assistance the person needed and what they were able to do themselves. We also saw details of the supplier of their moving and handling equipment as well as their contact details if any faults were found with this.

However, other care records continued to contain inconstancies and there were some care records without specific risk assessments in place where risks had been identified. For example, one person's support plan stated that they were at risk of urinary tract infections, but there was no risk assessment which addressed this or advised care staff how to manage the risk.

We spoke with the manager and other senior staff members about the continued inconsistencies in care records. They explained that they were in the process of reviewing and updating their care records but had not yet had sufficient time to update all care records. Senior staff explained that they were conducting care package reviews and were consequently updating care records as a result. At the time of our inspection we were told that approximately two thirds of care records had been updated and a plan was in place to review all care records.

At our previous inspection most people told us they administered their own medicines, but care workers reminded them to do this. Care workers were responsible for administering medicines for some people, but we found that this was not always recorded in the care records we looked at. We found limited evidence of medicines administration records (MAR) being filled in when required and in one of the few examples we saw where MAR charts were filled in, we found inconsistencies.

At this inspection we found MAR charts were being filled in. We requested MAR charts for people whose care records we reviewed and found these were being appropriately filled in by care workers. A system of audit had been put in place for senior staff to ensure that MAR charts were being filled in for all people who required assistance with their medicines. Where errors were identified when care workers completed MAR charts, they were required to attend training. Senior staff were in the process of reviewing all MAR charts for people they supported, but had not yet had sufficient time to review them all.

When questioned, care workers were clear about the medicines that people should be taking and told us they understood the importance of filling in MAR charts to make a record of the medicines they had administered.

At our previous inspection we found care workers had a good knowledge of how to identify abuse and what procedures they were required to follow to keep people safe. However, despite this, we found three examples of safeguarding concerns which had not been recognised by senior staff within the office as safeguarding matters and were therefore not reported to the local authority by Carewatch in a timely manner. At this inspection we found safeguarding concerns were reported to the local authority in a timely manner and safeguarding investigations were conducted as required.

At our previous inspection we found that when we looked at some people's daily records we saw numerous examples of people receiving care from one care worker when they should have had two. This included examples of people being hoisted by one person when they were required to be hoisted by two people. At this inspection we found people who required two care workers received this assistance. One person told us "Yes, there was an issue in the past, but this hasn't happened for a long time". Care workers also told us "I never hoist anyone on my own" and "If the person needs two carers, that's what they get. I wouldn't do anything on my own."

We have improved the rating for this key question from Inadequate to Requires Improvement as the provider had made improvements since our last inspection. However, this work was still in progress and we will conduct a planned comprehensive inspection in due course to check if the provider has fully completed these improvements and sustained them.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found people's needs were not met effectively as staff had not always taken appropriate action to ensure that people's rights were protected in relation to consenting to their care and support.

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.

At our previous inspection we found that the provider was not always meeting the requirements of the MCA. For example, we saw six care records where documentation was either signed by the person's next of kin without their having the legal authority to do so, was not signed at all or had 'UTS' recorded which meant 'unable to sign' without further explanations about why this was the case. We spoke with the director about this. They told us they were aware of the issues regarding documentation. They told us they had implemented a new process in care records which required the quality officer to record reference numbers for those people who had appointed someone with Lasting Power of Attorney or otherwise prompted them to undertake mental capacity assessments where required. We saw there was a section in the new needs assessment which contained these prompts. However, at the time of our previous inspection only a small proportion of people had these new records in place.

At this inspection we found a larger proportion of care records included details about people's mental capacity within the new section of the needs assessment. However, some people's care records did not contain these revised details. When we spoke with senior staff about this, they explained that they were updating these sections of the care records after conducting reviews of people's care packages. They explained that they had not yet had sufficient time to update all records, but had completed approximately two thirds of these records.

At our previous inspection we found care records contained limited information about people's healthcare needs and very little recorded information from healthcare professionals. At this inspection we found some people's care records contained clear information about their specific healthcare needs and contained details about healthcare professionals who were involved in their care. For example, one person's care records contained details about district nursing visits, their purpose and duration. However, not all care records contained up to date details. When we spoke with senior staff about this, they explained that they were updating these sections of the care records after conducting reviews of people's care packages. They explained that they had not yet had sufficient time to update all records, but had completed approximately two thirds of these records.

We could not improve the rating for this key question as to do so requires consistent good practice over

time. We will check this during our next planned comprehensive inspection.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that senior staff at the service did not investigate and respond to people's complaints. The service had a complaints policy which outlined how formal complaints were to be dealt with. Most of the people we spoke with and their relatives confirmed they knew who to complain to where needed. However, two people told us their complaints were not adequately responded to when they contacted staff at the office and we saw evidence of 18 complaints which had not been responded to. The director and manager of the service told us there had been an unacceptable delay in responding to these people's complaints and as a means of dealing with this, they had sent all complainants a letter apologising for their lack of response and requesting an update about the issues they had originally complained about in order to begin possible further investigations. The director explained they were now correctly implementing their procedure for dealing with complaints and they were working with quality officers to ensure that these were being escalated where required.

At this inspection we found that complaints were being responded to in a timely manner and where possible these were resolved to people's satisfaction. People's comments included "I've had a couple of problems, but I called the office and they sorted things out" and "I haven't had any complaints, but I can speak to [a senior member of staff] whenever I need to".

We saw evidence of complaints that had been received and the action that had been taken to respond to these. This was conducted in a timely manner in accordance with the complaints procedure.

We could not improve the rating for this key question as to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires Improvement

Is the service well-led?

Our findings

Providers are required to notify the Care Quality Commission (CQC) about significant incidents including safeguarding concerns. At our previous inspection we identified five safeguarding incidents that had not been reported to the CQC as required.

At this inspection we found significant incidents were reported to the CQC as required and investigations into incidents were conducted in a timely manner.

The service had an action plan to address the concerns identified in the previous inspection. The action was being implemented at the time of this inspection, but sufficient time had not passed for it to be fully embedded.

We could not improve the rating for this key question as to do so requires consistent good practice over time and further improvements were still being implemented. We will check this during our next planned comprehensive inspection.