Lakeside Care Services Limited

Carewatch (Bolton)

Inspection report

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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 caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This announced inspection took place over two days. On the 21 September 2016 we spent time at the office looking at records and on 06 October 2016 we contacted staff and people who used the service to seek their views and opinions on the service and the care provided.

The last inspection took place on 06 May 2014 as part of the Care Quality Commission (CQC) new methodology. The service was found to be meeting all the requirements reviewed.

Carewatch – Bolton provides care and support to people that enables them to remain in their own homes. Care is provided to people who require help with personal care and daily living tasks such as shopping and with the preparation of meals.

At the time of the inspection there was a registered manager in post. The registered manager was also the nominated individual for the company. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The service has had numerous changes in registered manager's position in the last two years. Some staff were unaware who was in charge of running the service at the time of the inspection.

A basic system was in place to audit how the service was operating. Improvements were needed in the quality of the monitoring. There was no evidence to show that the registered manager had been involved in the oversight of the service.

People we spoke with told us they felt safe with the staff that visited and supported them.
Both people using the service and relatives we spoke with said that staff had the knowledge and skills to do a good job.

People were very positive about the caring and compassionate nature of the staff that supported them. They told us that their privacy and dignity was maintained when being supported with personal care tasks. People we spoke with also told us they were always asked for their consent before care staff carried out any particular care or support tasks.

The service had failed to protect people against the risks associated with the safe management of medication. We also found gaps in the recording on food and fluid charts.

We found inconsistency in care files with the completion and updating of records.

Some of the wording on the daily records recorded by staff was inappropriate and not respectful. This was

discussed with senior staff during the inspection. The care plans we looked at were not person centred.

Risk assessments had been completed when the care package started. We found that these had not been reviewed in a timely manner.

The agency had corporate policies and procedures were in place. These were electronically held. There was no evidence to demonstrate that staff had read any of the policies.

There was a complaints policy in place, however not all complaints had not been responded to appropriately.

Comments received from people who used the service, relatives and staff felt the office staff were not always helpful and approachable, messages were not communicated to the appropriate person and that the on call system was not always available when required.

Comments by some staff raised concerns about a 'bullying' culture from some office staff if they questioned their work load. This sometimes resulted in care staff having their next day's calls taken off them and these calls were passed to other carers resulting in extra pressure on them.

Staff were not receiving regular supervisions or appraisals. Care staff spoken with said team meetings had not taken place.

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 consistently safe.

We found recruitment and selection processes were in place.

Some staff were unaware of the company's policies and procedures including safeguarding and whistleblowing procedures.

The service had failed to protect people against the risks associated with the safe management of medication. We also found gaps in the recording on food and fluid charts.

Both prior to the inspection and during this process we received information as a result of complaints and safeguarding from relatives of people who used the service.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not supported in their roles and care staff meetings were not held.

Formal supervisions were ad hoc and some staff had not received supervisions since commencing work.

Is the service caring?

Good

The service was caring.

People using the service were positive in their views about the caring nature of the care staff supporting them.

Staff we spoke with were able to describe how they promoted people's dignity and respect when providing individual care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had an individual assessment of their needs mainly completed by the local authority commissioning team prior to the service commencing. In most some cases the provider had not carried out their own assessments.

People knew how to raise a complaint if they had a concern or were unhappy with any part of their package of care. However some complaints had not been recorded or responded to.

Is the service well-led?

Inadequate

The service was not well led.

The service had a registered manager in place. There had been a number of registered managers within the last two years.

Systems where not in place to monitor the quality of the service. The registered manager had not checked the quality and safety of the service being delivered to people and effective action was not always taken to address shortfalls.

Some people using the service, who we spoke with, were not always informed if their carer was going to be late delivering their service.

The service was not open and transparent nor supportive to care staff.

Carewatch (Bolton)

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 checked 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 21 September 2016 and 06 October 2016 and was announced. The provider was given 48 hours' notice because we needed to make sure the registered manager would be available at the office to assist with the inspection. This inspection was carried out by one adult social care inspector.

Prior to the inspection we looked at information the service had sent to us including notifications and the previous inspection report. We also received a provider information return (PIR) from the provider. This form asks the provider to give us some key information about what the service does well and any improvements they plan to make.

On the 21 September 2016 we spent time at the office and looked at 10 care files, seven staff files, policies and procedures, staff training, staff supervisions and other relevant records. We spoke with the acting manager and the office staff.

Following the inspection we spoke with the local authority commissioning team, eight people who used the service and two relatives to obtain their views and opinions of the care and services they received. We also spoke with nine care staff.

Requires Improvement

Is the service safe?

Our findings

Some people we spoke with told us they received good care from the care staff who visited them in their homes. One person told us, "Mostly I am happy with the care, but weekends can be a problem, staff can be very late but that's not their fault they have too much to do". Another said, "I don't always know who is coming, it's not always the same person. I don't like that; I like to know who is coming into my house". Another person told us, "The girls that come to look after me are great".

We had received concerns from a family member about frequent missed visits, especially at weekend. The relative had discussed this with the office staff who were not helpful and with the local authority commissioning team. The family have since sought alternative care.

We were shown the company's policies and procedures. These were held electronically so were not easily assessable for staff to refer to if needed. We asked staff if they were aware of the safeguarding and the whistle blowing policy and what they should do if they had any concerns. Apart from ringing the office some staff were unclear and were not confident in reporting poor practice. We were provided with the 2016 training matrix and safeguarding vulnerable adults training was not listed. This was covered on induction but there was no evidence of updates. One staff file looked at showed that safeguarding was last completed in 2013.

There had been some safeguarding concerns raised and these were currently being dealt with by the local authority safeguarding team. The service had failed to notify the CQC of the safeguarding incidents. We are following this up outside the inspection process.

We looked at seven staff files saw that a satisfactory recruitment process was in place. Staff files included an application form, written references, other forms of identification and a Disclosure and Barring Service (DBS) check. A DBS check helps to ensure people's suitability to work with vulnerable people and informs the employer of any recorded convictions.

We found that medicines were not handled safely. For one person the service risk assessment completed by the local authority commissioning team stated that the person required a thickening agent in their drinks, this was to be made to a syrup thick consistency. The thickening of drinks is to help prevent choking when people have problems swallowing. This was a prescribed medicine and therefore should be recorded when care staff had administered any drinks. We asked the acting manager and senior office staff if there was documentation to show this had happened. We were told that care staff did not give any drinks to this person. The daily care notes recorded by staff clearly showed that staff were making drinks for this person. For example staff had signed to say on the 16/6/16 'cup of coffee made', '18/06/16 'made a cup of coffee' 25/07/16 'cup of coffee made', 27/07/16 'made a coffee'. From the 16/06/16 to 26/08/16 when the service ended there were 53 entries of staff making drinks, however there was nothing documented about thickener being added.

Following our inspection we received information from a relative informing us that a person who used the

service received four visits a day and at each visit medication was to be administered. The relative told us that on two consecutive days no evening visits had taken place and that medication was left in the dosette box. The medication included Amitripyline (anti-depressant) and Epilim (treatment for epilepsy). Failure to administer this medication could result in serious harm to a person.

We were also informed by another family member whose relative had diabetes and numerous other health issues that the bedtime call carer failed to observe this person taking their medication as one of the two tablets routinely administered in the evening was found on the floor by the breakfast call carer the next day. The family stated that whichever carer it was who was supposed to supervise this process in the evening did in fact attest to the fact that this had been done correctly when they signed the log book accordingly.

This was a breach of Regulation 12 (1) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because the service had not protected people against the risk associated with the safe management of medication.

We asked staff if they had access to personal protective equipment (PPE) such as disposable gloves and aprons to help prevent cross infection. Staff confirmed they did have access to PPE.

Requires Improvement

Is the service effective?

Our findings

Our findings
People who used the service told us they thought their regular care staff were well trained, they knew how to undertake personal care tasks and provide unhurried care. One person who received visits from their regular carers said, "I have a good relationship with my carers, they are brilliant, everything is running very smoothly at the moment". Another said, "They [staff] do everything they are supposed to do". Another person told us, "I get lots of different carers, but I am not bothered about that as long as someone comes".

We were provided with the staff training matrix for 2016. This evidenced gaps in training with some staff not having had refresher training as required. The training matrix showed that people on commencing work had completed an induction programme. We saw some evidence of this in the staff files we looked at. Information on the training matrix indicated only moving and handling and medication training was offered. There was no evidence of first aid, food hygiene, mental capacity or safeguarding or supporting people with dementia. Staff spoken with confirmed they had not had regular training updates. One member of staff told us, "I completed an induction at the beginning of my employment and I did receive training but have not had any since with two and a half years of being with the company".

We asked staff if they received regular one to one supervision meetings with the management. Supervision meetings provided staff with the opportunity to discuss any training and developmental needs they may have and to raise any concerns or issues. There was little evidence in the staff files to demonstrate that these meeting had taken place. We did see that some 'spot checks' had taken place for some staff. Staff spoken with told us they never went in to the office and had never had supervision meetings. Staff also confirmed they had never been asked to a team meeting. There was no evidence to show that staff meetings were held.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – staffing. The provider had failed to ensure that received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to do.

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 interest and as least restrictive as possible.

We checked whether the service was working with the principles of the MCA. There was an appropriate policy with regard to MCA; however staff spoken with had not seen the policy. Most staff we spoke with were unable to explain the principles of the legislation. Some thought it had been briefly covered on induction.

We looked at 10 care files at the office and found that the documentation was not current to reflect people

who used the service's current needs. We asked senior staff why records had not been updated. For example, for one person the risk assessments had not been updated since 24/09/13, for another the last moving and handling assessment was dated 25/09/13. Senior staff could not provide a valid explanation. They said they thought the care files in the homes were more up to date.

We saw for one person who required a food and fluid chart that the records had not been completed, for example on 13/09/16 only breakfast was recorded, there was no evidence of any other food or fluid offered that day. On the 14/09/16 there were no food and fluid entries at all. The entries that were recorded needed to be more specific, detailing how much fluid (mills) people had actually drank and the amount of food eaten as some recording stated, 'ate all'. We spoke with one person who used the service and asked about the care plan. They told us that someone from the office had been following our visit to update information. Senior staff during our visit told us they would need to go out and check that all the care files and assessments were up to date.

We saw no evidence of written consent to the care to be provided by staff from the person who used the service and/or their representatives, where appropriate. For example with regard to issues such as disclosure of information and agreements to keeping care plans in people's homes were included with in care files. We asked staff how they obtained consent to deliver personal care. One member of staff spoken with told us, "I always ask what people want before I do any personal care". Another told us, "I always ask for consent and give lots of support".

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance. The service had failed to maintain accurate records for people who used the service.

We asked about care plans audits and were told that a person from head office and been to the Bolton branch three months prior to our visit to audit the care plans. We were shown a spread sheet which detailed areas that needed to be addressed. None of recommendations was actioned. The registered manager and senior staff told us they had only just found the spread sheet on the computer.

Good

Is the service caring?

Our findings

People who used the service were complimentary about their regular carers, Comments included, "Brilliant", and "I love them coming, we have a good chat". Another person told us, "I am happy with the care, I mostly get the same carers coming. The girls that come are very polite and respectful and stay for the time they should. The weekends can be a problem with late calls and different people turning up". Another said, "In the main I am happy with the care I get. Some staff are better than others and will go the extra mile to help. Other just do the basics and are not as interested"

A member of staff spoken with said, "I absolutely love my job. I was thinking about leaving due to management and office situation but decided to stay so I was not letting my ladies down; they need care from people they know". Another member of staff said, "It's sometimes difficult to get round to people in the timescales given and to make sure that care tasks are completed.

We asked people if they were treated with dignity and respect. One person told us, "Absolutely, all of the staff that come to my home are very polite and courteous". Another said, "It's hard when you can't do everyday things for yourself, but my carers do everything they can to make it as easy for me as possible. They never make me feel embarrassed". People told us that regular carers made sure privacy was respected by closing doors and curtains before any care was provided.

We did see in one of the care records that a member of staff had written some inappropriate wording. We discussed this with senior staff and asked them to remind staff to be mindful of not using informal wording in daily reports.

In the care files we looked at we saw no evidence of people who used the service being asked their preference in having a male or female carer when attending to personal care tasks. This should be addressed at the start of the care package to avoid any distress to people who used the service.

We saw in some of the care files we looked at that a Customer Guide was in place providing information about the service. This included information about the company, what to expect and other important information.

Requires Improvement

Is the service responsive?

Our findings

Some people we spoke with and their relatives felt that care and support they received was not always responsive to their individual needs. This was mainly when new carers were sent and they were unfamiliar with their requirements.

People told us that the service did not always contact them if care staff were running late or had been changed. One person told us they would ring the office if their call was running very late to make sure someone was still coming.

We spoke to staff about the volume of calls they were allocated and if this contributed to them running late. One member of staff said, "It's sometimes difficult to get there on time especially as I have to walk." Another said, "They [office staff] just put extra calls on your rota and if you say you can't do them they take your work off you the next day, so people don't get their regular carer and it puts pressure on other carers".

Most people we spoke with confirmed there had been little or no discussions about their personal care needs and preferences from the agency prior to the service commencing. We found in the care records we looked at there was a service agreement that had been completed by the local authority as they were purchasing the care. There was no evidence to show that assessment /meeting had been completed by the agency. There was no evidence to demonstrate that carers had been introduced to the people they were caring for at the start of the care package to help ensure compatibility.

We looked at care records to understand how the service delivered personalised care that was responsive to people's needs. We found the care records lacked personal information, for example, there was no family history, nothing about interests and hobbies or how people like to spend their day.

We found in one file a customer review form dated 08/04/15. The form stated which staff were present at the review. The form stated that the person using the service would like more consistency with the times of calls. Another review on 16/05/15 stated the exact same comments. There was nothing recorded in the care files to say if these comments had been addressed or what actions had been looked in to. Another comment was made about the times of the night bedtime visit being too early as this meant the person who used the service would be in bed for up to 12 hours which they felt was too long. No actions were found in the file as to how this issue had been addressed.

In another care record we found the agency needs assessment and care planning had not been reviewed since 25/09/13. On the customer review form dated 11/03/16 it stated 'new care plan put in, file sorted'. The review also stated, 'would like some consistency with carers, different ones all the time and would like a phone call to say if carers are going to be late'. There was no evidence to show these concerns had been actioned. On the customer review dated 21/06/16 it stated 'needs a new care plan' there was no evidence to show this had been actioned at the time of our inspection. Staff spoken with in the office told us they did not know why some of the care plans had not been reviewed and updated.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – person centred care because the service had failed to carry out an assessment of needs and preferences.

There was a complaints policy and procedure in place. We looked at the complaints file to see how the service dealt with and responded to complaints raised. Not all the complaints the service received were logged in the file. This was information we were aware of as the CQC had asked the registered manager to respond to some complaints that had been sent directly to CQC. One relative spoken with told us, "I have made several complaints about missed visits, especially at weekends. These issues have not been resolved". They also raised concerns about how the office staff spoke with them and that they were not helpful. A member of staff told, "If you try to raise a concern or complaint you can't get past the office staff and nothing is done about it".

We asked staff about communication with the office staff. We were told that often messages did not get passed on to the relevant people. They said rotas get changed change at the last minute and staff were not told.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – receiving and acting on complaints because an effective system was not in place for identifying, receiving, recording, handling and responding to complaints by people using the service.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection there was 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 and associated Regulations about how the service is run.

The staff spoken with felt the service was not well–led. One person told us, "The office staff run the place not the manager". Another told us, "I have never met the manager, there is no visual presence from the manager, you just deal with the office". Other comments included , "It's no wonder people are leaving the way they treat staff, the wages are never right and there is always an excuse made as to why, they cram in too many calls so that people are getting rushed care or staff not staying for the time they should". Another member of staff also told us about problems with wages and call cramming.

Staff spoken with raised concerns about a 'bullying' culture from some office staff if they questioned their work load. This sometimes resulted in care staff having their next day's calls taken off them and these calls were passed to other carers resulting in extra pressure on them. The registered manager had not taken control of the situation in resolving the actions taken by office staff who were withholding work from carers when they raised concerns about their rotas.

We asked the registered manager and office staff about how the service operated after office hours. We were told there was an on call rota which covered evenings and weekends. This service was to cover calls from people who used the service and for staff. Staff spoken with said this did not work effectively. One member of staff said, "You can ring the on call and it goes to voice mail, if you leave a message you don't get a call back ". Another member of staff said, "If you do get through to the office the person on call does not always act accordingly". They gave an example of the on call person not being able to assist as they had problems with child care arrangements. This meant that staff were not receiving appropriate support when required.

Staff spoken with told us that the management arrangements were not satisfactory, that there was no consistency. They felt this was due to the number of registered managers that the service had employed over the last few years. One member of staff when asked if they met with the registered manager asked, "Who is it". Another said, "Oh I know who you mean but I have never seen him".

Staff also feedback that staff turnover was high and existing staff found it difficult to cover the extra calls to people effectively. Members of staff spoken with told us that if they raised concerns about the extra calls added to their rotas they had their calls removed the next day by office staff. This meant that extra calls were placed on people and the consistency of regular carers to people was disrupted.

We found little evidence that the registered manager had implemented effective systems to monitor and improve the quality and safety of the service provided. For example the recommendations from the care plan audit completed by head office had not been actioned. The audit took place three months prior to our inspection. We were provided with a basic medication audit that had been completed for six people by

senior carers. There were no other medication audits available and no analysis from the registered manager was available.

There was no evidence to demonstrate that accidents and incidents had been audited and if any actions were required.

We saw that some complaints/concerns had been logged in the complaints file, however we had been made aware of other complaints which we had brought to the attention of the registered manager that were not logged and therefore there was no conclusion of actions or lessons learnt.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance. The service had failed to implement systems to assess, monitor and improve the quality and safety of the service.

From speaking with staff and from looking at staff files we found that staff supervisions sessions were ad hoc. Staff comments included, "I have never had a supervision", another said, "They [senior staff] did once do a spot check". We did see some client (people who used the service) reviews, however this information had not been collated and any actions to address comments documented.

The service had corporate policies and procedures in place, which covered all aspects of the service delivery. The policies and procedures covered safeguarding, medication, whistleblowing and recruitment. These were held electronically and were not easily accessible to staff. Staff spoken with confirmed that they had not read the policies and some staff spoken with were not confident in how to deal with and respond to any safeguarding concerns or whistleblowing.

We were told by some staff that they were often allocated more than one call at the same time or had extra calls placed on their rota. There was no allowance made for staff to get between calls. Staff said despite raising their concerns with the office nothing changes. One member of staff said, "I don't complain otherwise they (office staff) will not allocate work for the next day.

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 9 HSCA RA Regulations 2014 Person-centred care The service had failed to carry out an assessment of needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not protected people against the risk associated with the safe management of medication

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints An effective system was not in place for identifying, receiving, recording, handling and responding to complaints by people using the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to maintain accurate records for people who used the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that received

appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to do.