Cannock Chase and South Staffordshire Care 28 Limited

Caremark Cannock Chase and South Staffordshire

Inspection report

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19 July 2017

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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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected this service on 18 and 19 July 2017. This was an announced inspection and we telephoned 48 hours' prior to our inspection in order to arrange home visits with people who use the service. This was the first inspection of the service.

Caremark Cannock Chase and South Staffordshire provides personal care and support to people living in their own homes in Cannock and the surrounding areas. At the time of our visit, 19 people were receiving a service.

There was a registered manager at the service. 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.

There were insufficient staff available to ensure people received timely support. People told us their calls were often late or rushed and staff felt under pressure to work long hours to ensure people's calls were covered. Staff did not always feel they were listened to and were concerned that staff morale was low due to high staff turnover.

People's medicines were not always managed safely. Staff did not consistently record when they administered medicines. Medicine records had not been reviewed or checked by the management team, so these issues had not been identified. The provider could not evidence staff received a suitable induction and adequate training to support them to fulfil their role.

The provider did not have effective systems to continually assess, monitor and improve the quality and safety of the service. There was a lack of oversight by the provider and registered manager to ensure that people received their planned care. They did not have a system to monitor for missed calls or review people's daily notes so they were unaware of any concerns or changes that needed to be acted on. The provider did not always notify us promptly of important events that occurred in the service.

Staff did not always follow the legal requirements when people lacked the capacity to make certain decisions. Staff understood the importance of consent where people had capacity to make their own decisions.

People had good relationships with the staff and felt safe when they supported them. Risks associated with their care and home environment were assessed and managed. Staff understood their responsibilities to protect people from the risk of abuse and were confident any concerns reported to the registered manager would be acted on. However, some staff were unsure of how to escalate concerns to the local safeguarding team if they needed to. The provider followed recruitment procedures to ensure staff were suitable to work

in a caring environment.

People's privacy and dignity was maintained and they were encouraged to be independent and follow their hobbies and interests. People managed their own healthcare needs but staff supported them to access other health professionals if required. Where needed, people were supported to have sufficient amounts to eat and drink.

People felt involved with the planning and reviewing of their care and felt confident raising any concerns or complaints. The provider had started to seek people's views on the quality of the service and planned to use the information to make improvements.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take 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 consistently safe.

The provider did not have safe systems in place to ensure people received their medicines as prescribed. There were insufficient staff and staff felt under pressure to work long hours to ensure people's calls were covered. Risks to people were identified and staff knew what action to take to keep people safe. Staff knew how to recognise and report potential abuse but were not sure how to escalate concerns to the local safeguarding team if needed. The provider followed recruitment procedures to ensure staff were suitable to work in a caring environment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We have recommended that the provider seeks advice on good practice to ensure they are meeting legal requirements where people lack the capacity to certain decisions. Staff did not receive adequate training to support them in their role. Staff knowledge and competency to fulfil their role was not checked by the provider. People were offered support with meals and drinks and to access healthcare professionals if needed.

Is the service caring?

Good

The service was caring.

People had good relationships with staff and were comfortable with them being in their home. Staff were kind and caring and respected people's privacy and dignity. Staff respected people's daily routines and encouraged them to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people did not receive support that was responsive to their individual needs. However, other people and relatives were happy with the support staff provided because staff understood

and respected people's cultural diversity and preferences. People had been involved in planning and reviewing their care. People and relatives felt able to raise any concerns or complaints.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

The provider did not have effective systems in place to continually assess, monitor and improve the service. Staff did not always feel listened to when they raised concerns about the service. The provider had begun to seek feedback on the running of the service and planned to use this to make improvements.

Caremark Cannock Chase and South Staffordshire

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 18 and 19 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We wanted to arrange home visits to people who used the service and to ensure staff were available to speak with us. The inspection was carried out by two inspectors.

We brought forward this inspection after receiving information from people who raised concerns about staff practice at the service. We reviewed statutory notifications the provider had sent us about important events that occurred in the service and spoke with commissions who arrange services on behalf of people. We used all this information to formulate our inspection plan.

On this occasion, we had not asked the provider to submit a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we gave the provider the opportunity to share information they felt was relevant with us.

We visited two people who used the service and their relatives in their own homes. We also telephoned a person who used the service and two other relatives. We spoke with the provider, the registered manager and four care staff. We reviewed records held at the service's office, which included three people's care records to see how their care and treatment was planned and delivered. We reviewed staff files to see how staff were recruited, trained and supported to deliver care appropriate to meet each person's needs. We

looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Is the service safe?

Our findings

There were insufficient staff employed at the service to ensure people received their care in a timely way. On the day we announced our inspection, the local authority advised us that the provider had contacted them to hand back five packages of care, because they did not have sufficient staff to provide the agreed calls. Staff told us some staff had left and calls were sometimes late or had occasionally been missed. One member of staff said, "I'm meant to be working as a senior care worker and doing some spot checks on staff practice but I am working full-time on care and picking up any gaps in the rota. I'm working around 65 hours per week and haven't been able to have any holiday for some time. I've been asking the provider to consider handing back care packages for weeks but they hadn't done anything about it". Another member of staff told us they had booked holiday for the week prior to our inspection but they had been asked to come in and provide care. They told us, "Due to staff shortages, they were constantly calling me to come in and I've worked four out of my seven days off and I've lost money from my holiday. I'm absolutely shattered". We discussed this with the provider who told us they had been having difficulty recruiting and retaining new staff and two new staff who had recently started were on holiday. They showed us how they allocated staff to fulfil calls but these were currently only being planned on a day to day basis due to the staffing problems they were experiencing. Records confirmed what the staff had told us and the provider confirmed that some calls had been missed or staff had been late for calls. However, they did not have any checks in place to monitor this and relied on people or staff calling them to report any concerns. This meant we could not be sure people were receiving their care calls as required and were potentially placed at risk.

People we spoke with told us that the staff were often late and their calls were sometimes cut short because staff had to rush to the next call. One person told us, "The staff are always rushed in the mornings and sometimes the staff leave after 30 minutes, although I'm supposed to have 45 minutes. Yesterday I felt guilty about wanting my shower as staff were in a rush". A relative told us, "They don't always come at the same time, sometimes they come too early in the morning and [Name of person] is still asleep". People and their relatives told us there was a problem with staff turnover, which meant that some staff were working long hours. One person told us, "Staff are working 16 hour shifts, working from 6am to 11pm and don't feel able to take time off if they were unwell, for example one has been working whilst having a chest infection". The member of care staff concerned had confirmed this to us. A relative told us, "We have a regular carer and I know she works long shifts; although she's always professional during the call, I worry about her coping and there's a risk of burn-out". We brought these concerns to the attention of the provider but as noted above, there was no suitable system to check if calls were made on time and for the agreed duration.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have safe systems in place to ensure that people's medicines were administered and managed safely. We visited a person who received support to take their medicines. We saw that medicine that should have been administered the previous day was still in the blister pack and a member of staff had signed the medicine administration record (MAR) to say that the person had received their medicines. The

member of staff who had administered the person's medicines on the day of our visit had not noticed this and was unable to provide us with an explanation. We discussed this with the provider who investigated and told us the person had received their medicine from a separate dossette box. However, this had not been noted on the MAR in the person's care folder and we had not been shown another dossette box during our visit. This meant the provider could not be sure that this person received their medicines as prescribed.

We saw that some people were prescribed medicines on an as required basis, for example for pain relief. However, the information to guide staff on how this medicine was to be administered was not sufficiently detailed. For example, it did not identify when the person would need the medicine, the required dose and spacing of the dose or the maximum amount the person could have in a 24 hour period. This meant the provider could not be sure these medicines would be given when needed and in a consistent way.

Staff told us they had not received any training to administer medicines whilst working for the provider. Some staff were unable to tell us what action they should take if they were concerned that a person had not received their medicines, for example if there was a gap in the MAR chart. We saw that the provider's policy stated that staff should not administer medicines unless they had attended mandatory medicine administration training and been authorised as competent by the care manager. We saw that the registered manager had provided medication awareness training during a recent staff meeting. However, there was no evidence that this had enabled staff to successfully complete the provider's mandatory medicines training, or that their competence had been checked. This meant the provider was not acting in accordance with their policies and procedures to ensure people were safe from the risks associated with medicines.

These issues are a breach of Regulation 12 (2)(g)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told they did us they felt safe with the staff. One person said, "I don't always know who's coming but I'm always happy to see them". People were not provided with a copy of the rota for their planned calls, which told them who would be coming. However, they told us they usually saw the same staff and they usually told them if somebody different was coming. Staff understood their responsibilities to keep people safe from abuse. They were able to identify the different types of abuse and told us they would not hesitate to report their concerns to the senior care worker or registered manager. One member of staff told us, "I report anything that concerns me and it's always taken seriously". However, one member of staff was not aware of how to escalate their concerns to the local safeguarding team if they felt appropriate action had not been taken. We brought this to the attention of the registered manager, who told us they would ensure staff had all the relevant contact details.

Before the inspection, we had received information that risk assessments and care plans were not always in place before people received support from the agency. The provider had submitted an action plan to us to show that these concerns were being addressed. Records we looked at showed that risks associated with people's care and their home environment had been assessed and plans were in place to guide staff on how to minimise these risks. For example, plans were in place where people were at risk of poor nutrition or developing sore skin due to pressure damage. We saw that plans were reviewed and updated to ensure people continued to be supported in a safe way.

The provider checked staff's suitability to deliver personal care before they started work. Staff told us they were unable to start work until all of the required checks had been completed. Records we looked showed that references were sought and a check carried out with the Disclosure and Barring Service, which keeps records of criminal convictions. This showed us the provider followed the necessary procedures to demonstrate staff were suitable to work in a caring environment.

Requires Improvement

Is the service effective?

Our findings

People and relatives had no concerns about the regular care staff that visited them. However, when new staff visited, they told us they did not always have sufficient training. One person said, "The two regular staff I have are spot on and know exactly what they are doing, but some of the others haven't had enough training, particularly in using the hoist. They usually come with one of my regular carers so I let them know if I'm not happy with anything". A relative told us, "[Name of person] usually has the same carers but they had a new carer with them the other day and I'm not sure they'd had much training in how to provide [Name of person's] care". One newly recruited member of staff told us, "I was shown how to use the hoist in the office and I have had the opportunity to shadow other staff to get to know people's needs, but I haven't received any other training yet". Another member of staff told us, "My induction was two days. The training consisted of watching some health and safety videos and one on safeguarding, which took about an hour to complete". A third member of staff told us, "The induction needs to be improved, staff don't spend long enough shadowing to get to know people better". The provider showed us the induction programme which covered a range of topics, including safe moving and handling, managing medicines, food hygiene and first aid. This included practical training and e-learning, which would be refreshed on an annual basis. However, there were no records to show how the training was being delivered to staff and we had found poor practice in the safe management of medicines and uncertainty about how to escalate safeguarding concerns. In addition, there was no reference to training in the Mental Capacity Act and associated Deprivation of Liberty Safeguards, where we found some staff lacked understanding of the legal requirements. We have discussed this in more detail in a subsequent paragraph of the report.

The provider told us that staff were trained by the registered manager and the senior care worker, who both had extensive experience in care. Whilst the registered manager held a train the trainer qualification, this was not in safe moving and handling or medicines management. This meant we could not be assured that the training staff received was up to date and followed good practice. Staff told us, and records confirmed they had been enrolled on nationally recognised courses including the Care Certificate, which supports staff to achieve the standards required to work in health and social care settings. However, they told us they had to do this in their own time. One member of staff told us "I've only been able to look at one or two areas as I'm working so many shifts. I'm also doing a course in dementia care but I get so little time and if we don't complete the work in a set time we can get fined by the college". This meant people may be cared for staff who may not have the skills and knowledge to meet their needs effectively.

This is a breach of Regulation 18 (2)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some staff told us the registered manager had begun to hold supervision meetings with them, although the arrangements were not formal and there was no set agenda. The registered manager told us they had not had a formalised supervision meeting with the provider. However, they felt supported in their role and as they worked closely together, they were able to discuss any concerns as they arose.

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.

We checked whether the provider was working within the principles of the MCA. Care records we looked at showed that mental capacity assessments where in place for two people who were unable to consent to their care and support. We saw that these people's relatives had signed to consent to their family member's care and support. However, the assessment stated that there was no lasting power of attorney in place, which meant the person's relative did not have the legal authorisation to make decisions on their behalf. In addition, there was insufficient detail to show how the decision had been reached and who had been involved. We discussed this with the registered manager, who was not aware that the person's next of kin was not automatically able to give consent on behalf of their relative. As noted above, staff had not received training in the MCA and DoLS and discussions demonstrated that staff lacked understanding of the legal processes to be followed to ensure people's rights were upheld. For example, some staff had not heard of DoLS.

We recommend that the provider seeks advice on best practice, to assess people's capacity in relation to specific decisions in relation to their care and treatment.

People and their relatives told us the staff asked people for their consent before providing care. A relative told us, "I could hear the staff talking to [Name of person] in the bathroom asking first before they washed them". Staff we spoke with knew about people's individual capacity to make decisions and understood their responsibilities to support people to make their own decisions. A member of staff told us about how they supported people to make day to day decisions. They said, "I always ask people when I'm assisting them and if they said no, I would ask them again later; I would never force them". This showed the staff understood the importance of gaining consent where people had capacity.

We saw that people who were supported with mealtime visits were offered a choice of meals and staff encouraged them to eat and drink sufficient to maintain good health. One person told us, "Staff give me my breakfast cereals and leave me with some toast which I nibble on later if I get hungry before they come again at lunchtime". Records showed that nutritional plans were in place where people had specific dietary needs and staff reported any concerns to the office ensure that the appropriate action could be taken; for example, follow up with the person's GP or the district nurse.

People retained responsibility for managing their own health care. Staff told us they reported any concerns to people's relatives, who would then arrange for the GP or district nurse to visit. A relative told us the staff were proactive in ensuring people's day to day health needs were met. They said, "Staff pick up concerns with [Name of person's] health and we get the district nurse in when needed".

Good

Is the service caring?

Our findings

People and relatives were complimentary about the staff. One person said, "My regular carer is fantastic, the best carer in the world". A relative told us, "We can't sing [Name of care worker's] praises highly enough. [Name of person] has taken a real shine to her; they work so hard with her". Some people and relatives said that although the staff were frequently stretched, this did not impact on the care they provided. A relative said, "They are so busy but [Name of carer] deals with things very well, it never comes across as affecting [Name of person's] care. One member of staff told us, "My concern is always for the clients". People and relatives told us they got on well with the staff and were comfortable with them being in their home. One person said, "They are almost like friends". A relative told us they looked forward to the staff visiting and could have a laugh and a joke with them. Another relative laughed and told us their relative preferred the carers to them helping, "[Name of person] is very appreciative; we get flak when we are helping them, the staff get all the thanks". A third told us, "[Name of person] doesn't take to people lightly but always gets on well with the staff; they made a big fuss and sang happy birthday on their birthday". This showed us staff cared about people's wellbeing.

We saw that staff treated people with respect and showed respect for their personal belongings. For example, we saw that a carer asked a person where they should plug in the hoover because they didn't want to disconnect the person's computer. Staff promoted people's dignity by covering people with towels when providing personal care and ensuring doors and curtains were closed.

People told us the staff respected their daily routine and staff always asked them what they needed before supporting them. We saw that people had been asked for their preferences in all aspects of their care and their choices and decisions were reflected in their care plans. One person told us their close friend was kept involved with their care and support. They said, "The staff keep a book and write notes to my friend who lives close by. The member of staff told us, "[Name of person's] friend does all the shopping so we jot down anything that's needed or anything else that we need to pass on; it works really well".

People were encouraged to maintain their independence. Staff told us, "We are there to support not take over, which helps people remain in their own homes".

Requires Improvement

Is the service responsive?

Our findings

We received mixed views when we asked people if they received personalised care that was responsive to their needs. One person told us they had difficulty contacting the out-of-hours service when they had an emergency. They told us , "I contacted the number several times and even left a message on the office number. When they eventually answered, the staff member said they hadn't got a signal. The staff did not come to me any earlier as I had requested and I was left in a state of discomfort until the carers came for my bedtime call. I have never been in a situation like that before". The person told us they had spoken with the provider, who was due to visit them to discuss their concerns. The provider assured us that the incident would be referred to the local safeguarding team for advice and they would investigate.

Other people and relatives were happy with the support staff provided. For example, a relative told us how staff were responsive to the needs of both of their relatives, although they were only providing support to one of them. They told us, "The staff know what our concerns are and make sure things are ok and let us know if there is a problem". This showed us people's needs were looked at holistically. We also saw that people's preferences for the gender of their carer were respected. Discussions with relatives demonstrated that staff understood people's social and cultural diversity and respected their preferences for their support. We saw that people were supported to follow their hobbies and interests. Staff chatted with people about their favourite TV programmes and made sure people had books or the TV on before they left them to go to their next call.

People had agreed how they wanted to be supported and had a copy of their care records in their home. Some people and relatives told us the registered manager or provider had telephoned or visited them to see if they were happy with their care and if any changes were needed. One person told us, "I've had a visit to see if everything is okay". We saw that people's care plans were updated to reflect any changes. This ensured people's support continued to meet their needs and preferences.

People and their relatives told us they knew how to raise concerns and complaints and felt comfortable doing this. One person told us, "I tell the care staff if I'm not happy with anything". Another said, "I'm happy to speak out about anything". A relative told us they had met with the provider when they had concerns about a member of staff and action had been taken to resolve the matter. We saw people had received a copy of the complaints procedure. Records showed that complaints were investigated and responded to in line with this.

Requires Improvement

Is the service well-led?

Our findings

We found the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. We had identified concerns with the administration of medicines and saw that there was no system in place to check that medicine administration records had been completed correctly. Records we looked at for two people showed that the medicine administration record (MAR) had been completed by the provider and did not have two staff signatures on to show that it had been checked for accuracy. In addition, the MAR were not always dated and there were numerous gaps. This meant the provider could not be sure people received their medicines as prescribed. We saw an action plan which showed the provider had recognised the need for improvement in the management of medicines. However, this had not been effective in addressing the shortfalls we had identified.

As already noted, we saw that the provider had taken action to ensure risk assessments and risk management plans were in place and reflected people's current needs. However, there were no checks carried out on the daily logs staff completed to record their time of arrival and departure and details of the care being provided. We saw that one person's record did not have an entry for two of their calls and there was no evidence that the provider monitored these records for accuracy. Failure to carry out these checks demonstrates a lack of oversight to ensure any concerns were identified and addressed promptly and placed people at risk of not receiving their planned care. The provider told us the registered manager and senior care worker carried out spot checks of staff practice. However, due to staff shortages, both staff had been unable to carry out these checks on a regular basis. This meant the provider was not effectively monitoring staff practice to identify shortfalls and make improvements where needed.

This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found that the provider and registered manager did not always ensure they met the requirements of registration with us. We found that notifications of important events that occurred in the service were not always sent to us. For example, the provider did not always notify us when concerns had been referred to the local safeguarding team and we had not been notified of a change in the provider's registered address which had taken place at the beginning of June 2017. This enables us to check that appropriate action has been taken. Following the inspection, the provider forwarded the notification as required.

Staff told us they generally felt supported and able to give their views on the running of the service. However, they felt that they were not always listened to and were concerned that staff morale was low due to high staff turnover. The provider had recognised the need to address the high turnover of staff at the service and had taken steps to improve staff morale, for example providing an area in the open plan office for staff to relax during calls.

People and relatives told us the provider, registered manager and staff were approachable and felt able to discuss any concerns with them. The provider had started to develop governance arrangements and met with the registered manager and senior staff on a weekly basis to monitor the service. They had also carried

out some visits to people to gather their feedback on the service. They told us they planned to carry this out on a regular basis to make improvements in the service people received.

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 provider did not have safe systems in place to ensure that people's medicines were administered and managed safely. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff employed at the service to ensure people received their care in a timely way. Regulation 18(1) Staff did not receive adequate induction, training and support to meet people's needs effectively. Regulation 18(2)(a)