Carewatch Care Services Limited

Carewatch (Southampton)

Inspection report

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12 October 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place between 8 October 2018 and 12 October 2018. We gave the provider 48 hours' notice of our intention to visit their office on 11 and 12 October so that we could be sure the registered manager or a senior staff member would be in.

This was the first inspection of Carewatch (Southampton) since they re-registered with us following a change of office. Our decision of when to inspect the service took into account information we had received from the local clinical commissioning group.

Carewatch (Southampton) is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older people and younger adults. People using the service may be living with dementia, mental health needs, learning disability, autism, physical disability or sensory impairment. At the time of our inspection the service supported 250 people. There was a small number of people supported 24/7 by live-in carers.

Not everyone using Carewatch (Southampton) received the regulated activity of personal care. CQC only inspects the service being received by people provided with personal care, which includes help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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

Following concerns raised by the local clinical commissioning group and identified by the provider's own quality assurance processes, the provider had been executing a quality improvement plan which had delivered improvements. Some of these improvements in the areas of record keeping in relation to medicines and risk assessments were yet to be fully embedded in staff practice at the time of the inspection.

The provider had processes in place to protect people from the risk of abuse and other risks to their safety and wellbeing. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

There were sufficient numbers of suitable staff deployed to support people safely according to their agreed rotas. The provider's recruitment process was designed to make sure only people suitable to work in a care setting were employed.

The provider had processes in place to protect people from risks associated with the spread of infection.

Where accidents or unwanted incidents occurred, these were analysed to identify any learning which could improve the service for people.

The provider had detailed assessment and care planning processes which led to good outcomes for people. Staff were trained and supported to obtain and retain the skills and knowledge necessary to support people effectively. The provider worked with other agencies and healthcare services to deliver effective care and support. The provider supported people to live healthy lives and maintain their independence. Staff were aware of the need to seek consent for people's care and support.

Staff treated people with kindness, respect and compassion. Staff supported people to express their views and to be involved in decisions about their care and support. Staff respected people's dignity, privacy and independence.

People received care and support that met their needs and reflected their preferences. Where people raised concerns or complaints, they were listened to. People were supported at the end of their life to have a comfortable, dignified and pain-free death in their own home.

The provider had managed improvements to the culture and atmosphere of the service. There were management systems and a quality improvement plan in place to sustain and embed these improvements. People who used the service and staff were engaged and involved in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Records relating to the management of medicines and risk assessments did not always show that these areas were managed safely.

There was a risk identification and assessment process to protect people against the risks of abuse and unsafe or inappropriate care.

People were supported by sufficient numbers of staff. Staff were checked as suitable to work in people's own homes.

People received their medicines from staff who were trained and assessed as competent. People were supported by staff who were trained in infection prevention and control.

Is the service effective?

Good

The service was effective.

People's assessments and care plans were thorough, detailed, personalised and based on relevant standards and guidance.

People were supported by staff who had the required skills and knowledge to support them effectively.

People's care was effective because the provider worked together with other agencies and supported people to have access to other healthcare services.

Is the service caring?

Good

The service was caring.

People had caring relationships with their care workers.

People were supported to take part in decisions about their care, including care reviews.

People were treated as individuals with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's care and support considered their needs, preferences and wishes.

The provider was responsive when people raised concerns or complaints about their service.

Enhanced care plans were in place for people at the end of their life.

Is the service well-led?

Good

The service was well led.

The provider had managed improvements to the service and established an effective governance system.

People who used the service and staff were supported to take an active role in the service.

There were plans and systems in place to improve the service and sustain improvement to the benefit of people who used the service.

Carewatch (Southampton)

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

We were aware that the local clinical commissioning group had an ongoing large scale enquiry in progress, and we took this into account when scheduling the inspection.

The inspection took place between 8 October 2018 and 12 October 2018. We spoke with people who used the service and their family members by telephone on 8 October, and gave the provider 48 hours' notice of our visit to their office on 11 October and 12 October. This was to make sure people we needed to speak with would be available.

The inspection team consisted of an inspector and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this inspection the Experts by Experience carried out telephone interviews to gather evidence about people's experience of using the service.

Before the inspection we reviewed information we had about the service, including notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

We had not asked the provider to complete a Provider Information Return (PIR) because we had brought the date of the inspection forward. 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. We obtained information about this by talking with the registered manager and other senior staff during the inspection.

We spoke with 15 people who used the service or their family members. We spoke with the registered manager, the area manager, a quality service improvement manager and five care workers.

We looked at the care plans and associated records of 11 people. We reviewed other records, including the provider's policies and procedures, internal checks and audits, the provider's improvement action plan, quality assurance survey returns and reports, training and supervision records, medicine administration records, and recruitment records for two recently recruited staff members.

Requires Improvement

Is the service safe?

Our findings

People we spoke with consistently told us they felt safe while their care workers were supporting them with personal care. Many had a long-standing relationship with their care worker which helped them feel safe during care visits. One person said, "It is important to have a routine and to have carers who understand what needs to be done, know me and what is wrong with me." There were no concerns raised about how care workers supported people with their medicines. People told us care workers followed good practice with respect to cleanliness, hygiene and measures to prevent the spread of infection.

Although feedback from people who used the service was positive, we found some examples where the provider's record keeping did not show that processes and procedures in place to keep people safe were always followed. The provider had a system for identifying and assessing risks to people's welfare, but this was not always followed through. One person had chosen to use bed rails to manage the risk of their falling from their bed. The use of bed rails itself introduces other risks. Staff had carried out a risk assessment, but it had not been added to the person's care file. This meant they were at risk of unsafe care because care workers had not been informed of actions to manage the risk. Another person, who was supported full time in their own home, was at risk of not drinking enough. The registered manager told us there were no concerns about the person's intake of fluids. However, the risk had been identified, and there were no records in place to show care workers monitored the person's fluids.

The provider had identified that care workers did not always complete medicines administration records to show people had their medicines as prescribed. They had in place an improvement plan which focused on improving the quality of medicines records. We found some examples of poor recording in older care records we saw. However, the provider's own checks had found no gaps in records in the month before our inspection.

Where people had medicines prescribed to be taken "as required", the provider did not always have clear instructions for care workers about when and why to administer them. Protocols for this were in place for pain relief medicines such as paracetamol, but not for creams and ointments prescribed to be applied "as required".

Records were not always consistent. One person's skin health risk assessment stated a barrier cream should be applied at every visit, but their medicines administration record instructed care workers to apply the cream once a day when needed. Another person's care plan stated, "I will require you to administer my medicines ensuring I have taken them before you leave." Their medicines records showed in fact these medicines were frequently left for the person to take themselves. The registered manager told us they would correct the person's care plan, as the person had capacity and was able to take their own medicines with assistance from their family.

Another person's records showed they had not had prescribed creams applied because they were "not required". Not all the creams had been prescribed to be applied "as required". The registered manager was aware of the situation, which had been caused by supply problems outside the provider's control. However,

they agreed the records were not accurate.

Where we found concerns with records the registered manager was aware of them and had an improvement plan in place to address them. We recommend the provider continue to monitor and evaluate the existing quality improvement initiatives until improvements are shown to be sustained and embedded in practice.

There were systems in place to protect people from the risk of abuse. Staff were well informed about the types of abuse, signs to look out for, and how to report concerns. They were confident concerns would be dealt with appropriately if they raised them. The local authority guidance and multi-agency toolkit for handling safeguarding concerns were available for staff to refer to.

Where concerns had been raised, the registered manager followed the provider's policies and procedures to investigate, and take appropriate disciplinary action if necessary. Safeguarding concerns were reported to us, and to the local authority safeguarding team. The provider reviewed safeguarding incidents every three months to proactively identify any trends or patterns.

Where risk assessments were in place, they were detailed, thorough and individual to the person. Examples included risk assessments for moving and positioning, bed rails, skin health, support with money, and support in the community. Risk identification considered the control of substances hazardous to health (COSHH), fire safety, scalds and burns, trips and falls, safe eating and drinking, overnight care, and safety to avoid restraint. Where necessary risk assessments were cross referenced. One person's diabetes risk assessment dealt with dietary advice, and pointed care workers to the person's choking risk assessment. This meant management of one risk took into account other associated risks.

One person was at risk of behaviours staff might find challenging. There was an individual behaviour support plan in place. This had been drawn up with the involvement of the person's family and their regular care workers. It contained information about events which might trigger behaviours, signs and strategies for avoiding the unwanted behaviours and managing them in the least restrictive way possible.

Environmental risk assessments were in place to identify risks associated with providing support in people's own homes. These included a safe working risk assessment, general conditions, infection control, pets, and food. The risk assessments identified equipment and clothing required to maintain hygiene and avoid the risk of the spread of infection. Any training required for staff to support people safely was also identified.

The provider had a business continuity plan which covered access to IT and data, access to premises and availability of staff. There were sufficient numbers of suitable staff to support people safely according to their rotas. Employed staff provided cover for leave and absences, including office staff who were suitably trained.

The provider's recruitment processes were designed to make sure staff employed were suitable to work in a care setting. Records were in place to show the necessary recruitment checks were made. Before working alone in people's homes, new care workers had induction training and a period shadowing experienced colleagues.

People received support with their medicines from staff who had all recently had compulsory retraining in this area. This applied both to care workers and the quality officers whose role included checking and auditing medicines administration records. Where these checks and audits identified staff who were not able to meet the provider's standards after retraining, the registered manager followed up individually in line with the provider's performance management and disciplinary procedures.

Staff induction training covered processes to prevent infection and protect people from the risk of the spread of infection. This included the basic knowledge required, personal protective equipment, food hygiene and hand washing. It was followed up by quizzes, and included in spot checks and supervisions to make sure the learning was retained.

The provider had systems in place to learn lessons and make improvements when things went wrong. There was a clear process for reporting incidents, which were analysed every six months for trends and patterns. Lessons which emerged from this process were escalated to the quality and training teams and shared within the provider's organisation.

Recent lessons learned memos had covered record keeping, care planning and risk assessment. Where the local authority had identified areas for improvement, the provider had made changes which included changing the format of the daily care log books to reduce the risk of poor record keeping. People using the service could be confident the provider learned from experience and made changes to improve the service they received.

Good

Is the service effective?

Our findings

People we spoke with were satisfied their care workers had the skills and knowledge to support them effectively. One person said, "They just completed a course and exams. They passed." Care workers we spoke with told us they had the right amount of training, and were supported by regular supervisions and spot checks. Care workers also said that people's care plans contained the information they needed to support people effectively.

People's care plans were based on thorough assessments of their individual needs. They covered areas including medicines, safety, continence, mobility, skin health, falls prevention, other health considerations and personal care. Staff carrying out people's assessments had access to specialists employed by the provider. These included staff with expertise in advanced care, learning disabilities, and behaviour that challenges.

Care plans were written in line with internal and external guidance. The provider had their own protocols for certain conditions, such as epilepsy care. In other cases, NHS guidance, such as for asthma, was downloaded and used. Other guidance referenced in the provider's policies included from the Department of Health, National Institute for Health and Care Excellence, the Social Care Institute for Excellence, and the Mental Capacity Act 2005 Code of Practice. People's care and support was based on current standards and guidance.

The provider's induction and follow up training was designed to make sure staff had the necessary skills. There was a five-day classroom induction which covered mental capacity, safeguarding, dementia care, first aid, person centred care, and infection protection and control. This was followed by a 12-week period during which staff completed an induction workbook which was based on the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

After their induction, staff could access more specialist and advanced training, for instance supporting people with a tube feed and dementia care. Office staff had recently completed customer service training. There were regular refresher courses, and records showed these were up to date. Records also showed supervisions, spot checks and appraisals were up to date in line with the provider's schedule for these.

Where people's care plans included supporting people to eat and drink, there was individual guidance about how to prepare people's food, for example if they needed a pureed diet or thickened fluids. There was also guidance on how to support people, for instance "stay with me while I eat".

The provider worked effectively with other organisations to deliver care and support that met people's needs. This included working cooperatively to improve the experience of people who were discharged from hospital to their own homes. There was positive feedback from other professionals. One referred to "outstanding care and compassion", a detailed history of the person, and an offer by staff to help and

provide advice on how to approach the person and their family. A written compliment from a family member of a person who used the service referred to the provider's knowledge of services available from other organisations and the impact this had on them and the person. They wrote, "Expertise and experience regarding additional outside agencies was brilliant. Angels really do exist, they wear Carewatch uniforms."

Staff supported people when they had appointments with their GP or with community nurses, and cooperated with people's social workers. Written feedback from one social worker referred to a "positive review", and that the person was "happy and well cared for".

Care workers we spoke with were aware of the need to seek people's consent for their care and support. People we spoke with told us they had no concerns in this area. There were consent forms in people's care files which showed they had consented to their care and support. In one case the person was not able to sign, but their representative had completed the form to show the person had expressed their consent verbally. Where people had appointed a lasting power of attorney to handle their financial affairs or health and welfare, the provider either checked the relevant paperwork or confirmed with the office of the public guardian that the arrangement had been officially registered.

The Mental Capacity Act 2005 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. Where a person was assessed as lacking capacity records were in place to show that a best interests process had been followed which was in line with the Act and the associated code of practice. The registered manager was a qualified Mental Capacity Act trainer and had made sure by means of appropriate training that staff were aware of how to protect people's human rights under the Act.

Good

Is the service caring?

Our findings

People we spoke with described caring relationships with their care workers. One person said of their care worker, "She worries about each of us individually and does extra things above what she needs to. She is more of a friend than a carer." Another person said, "My regular weekday carer is a nice girl. I get on well with her and she's very obliging to help."

Care workers we spoke with showed kindness and compassion. Many had been supporting the same people for a number of years, which gave them time to develop a caring relationship, and to get to know people well. One care worker said, "If you go regularly, you know if people are not well or unhappy." Another care worker described how a person they supported had remembered their name for the first time. The care worker had asked why they had remembered her name, and the person had replied "because you are caring and nice to me".

Thank you cards sent by people's families also referred to care workers' kindness and compassion. One card read, "The team not only did their job, they became friends and they did over and above what was asked." Another family member had written, "Mum trusted [care workers] completely, as did we."

People and their representatives were involved in regular care plan reviews where they were invited to provide feedback on their care workers. One comment read, "The carers are always going above and beyond for me." Other comments described care workers as "wonderful" and "friendly and caring".

Another person's representative had written, "Excellent work in conducting review of [Name's] care plan. [Name's] paperwork is now all up to date, and [Name] feels valued and pleased he was listened to." Records showed people and their families were involved in decisions about their care at assessment, care planning and care plan reviews. Care plans were written to involve people in day to day decisions about their care and support. One care plan prompted staff to check what the person would like for dinner.

People we spoke with told us their care workers respected their privacy, dignity and independence. One person said, "They are very discreet with all that they do." Another person's family member told us the person felt she was treated with dignity and respect, and the support they received "enabled them to remain independent". Another family member told us, "They are respectful to his home and treat him with dignity."

Care plans were written in a way that encouraged care workers to respect people's privacy and that of their family. Where people lived with other family members, their care plans described exactly where their rooms were in the property. This meant care workers could avoid inadvertently taking them into another family member's room.

Care plans were written to support people to be as independent as possible. One care plan stated, "[Name] can walk independently if given time to get his balance."

At the time of our inspection none of the people using the service had particular needs arising from their

religious or cultural background. Staff induction training included equality and diversity, which meant care workers understood the type of reasonable adjustments they could make. One care worker told us how a person's care plan contained information about their chosen religion which meant they could use this as a conversation starter.

Good

Is the service responsive?

Our findings

People we spoke with consistently told us they received care that met their individual needs and reflected their preferences and wishes. This was reflected in their care plans which were detailed and individual to the person. Care plans contained information about the person's likes and dislikes, life history, important relationships, pets, community activities and significant dates. This allowed care workers to respond to and engage with them as individuals.

Care plans laid out the relevant care and support activities, relating them to the person's aspirations and objectives. They detailed how to support the person, making clear what the person could do themselves, and how care workers should interact with other carers and family members. Where people's support took into account specific medical conditions, their care plans contained general information about the condition and explanations about how the condition affected the person individually.

The provider responded to people's changing needs. When a care worker noticed a person's mobility had declined they notified the office who arranged a visit from an occupational therapist. There had been occasions when poor communication between staff had delayed the response to people's changing needs. The registered manager had put in place changed office procedures to address this. These changes had been effective, although one example of a previous communication failure came to light during our inspection.

People's care plan reviews also covered how successful their care plans and risk assessments had been in meeting their needs. Where a person was at risk of poor skin health, their care plan review confirmed that they had not sustained any pressure injuries in the period since the last review.

Where people had individual communication needs, these were reflected in their care plans to enable care workers to make sure people had the information they needed to understand their options and make decisions about their care and support. One person used assistive technology and this was explained in their care plan. Another person's care plan explained they were not able to communicate verbally but could nod or shake their head in response to short, simple sentences. Another person who had had a stroke used hand gestures, but their care plan instructed staff to encourage them to speak as part of their therapy.

The service supported people in the community, providing social care as well as personal care to a person with a learning disability, which helped them to live as ordinary a life as any other citizen. Another person with a physical disability was supported to remain at work. When they retired they wrote, "Thank you for all the fantastic service you have given me."

All the people we spoke with were aware of how to make a complaint if they needed to. Two people had complained in the past, and both were satisfied with how their complaint was managed.

When people started to receive personal care services from the provider, they received a service user guide which included the provider's complaints process. They were reminded of this during care plan reviews, and

prompted if they had any concerns about their care to consider if a formal complaint was appropriate.

The provider's complaints log showed that there had been 20 formal complaints since May 2018. These had all been acknowledged, followed up and a report made back to the complainant. Complaints were analysed every three months to identify actions, such as staff training, and other lessons to be learned.

A person who had been diagnosed as near to the end of their life had an enhanced care plan in place. This made clear what the person could do for themselves, and how care workers should support them while working with community nurses and the palliative care team.

The enhanced care plan covered the person's comfort, mobility, skin health, medicines, pain management, other symptoms and food and drink needs. It included guidance about mouth and eye care, washing, dressing and the person's personal grooming preferences. It considered the person's communication needs, social, emotional and religious needs, and how care workers could support the person's close family.

The provider had an end of life care specialist who could be consulted by staff when developing a person's enhanced care plan. They also took specialist advice from other agencies, such as Macmillan nurses.

The provider's policy for end of life care planning included care delivery, religious and social needs, recognising when people might be entering their last days of life, support after death, and staff training and support. The provider had systems in place to support people at the end of their life to have a comfortable, dignified and pain-free death.

Good

Is the service well-led?

Our findings

People we spoke with all indicated they had been contacted by the provider either to complete a customer survey, for an assessment or care plan review, or for some other reason to do with their care and support. One person said, "I met one manager. They are wonderful when I phone, and I am sure they would be there if I need. I am very happy with the company as it is." Another person said, "I haven't met the manager, but I have had supervisors visit. They are generally friendly and helpful when I phone." A third person found the service "well managed overall" with good communications. However, another person had a less positive experience. They said, "The office staff are rubbish, but the carers are OK."

The registered manager had taken steps to improve poor staff morale caused by a history of inconsistent management which had led to a culture which was not always empowering, open and inclusive. The registered manager told us they had been "firm with staff" about improving the culture, and had used the provider's performance management and disciplinary procedures where necessary. They had been supported in this by the area manager and a peer manager within the provider's organisation.

The registered manager had concentrated on improvements to quality monitoring and encouraged team working, communication and empowerment. Staff we spoke with responded well to the registered manager's style and objective to put into practice the provider's mission statement, which was to encourage respect, quality and positive outcomes for people. One staff member said the registered manager "can speak to you, and is open to ideas". Another staff member recognised that the previous turnover of managers had been detrimental.

There was a governance system in place which made responsibilities clear and put quality improvement at the centre of the service. The registered manager had written to all staff setting out expectations and how improvements would be managed. This had included refresher training followed by increased focus on internal checks and audits. Concerns identified in these checks and audits were followed up initially with an informal warning and then by a formal meeting with the registered manager.

The registered manager was supported by the provider's quality team who carried out planned and unannounced quality assurance visits. These included monitoring of people's experiences by telephone reviews and home visits. Where these visits had identified areas for improvement, actions were managed by means of a quality improvement plan. There was also a self-assessment process undertaken by the registered manager. This covered structure and management, scheduling and rotas, care planning review and risk management, staff management, monitoring and measurement, and training. Progress against the improvement plan was monitored regularly.

The most recent quality assurance report gave the service a score of 92% against a benchmark of 85% which meant the service was no longer seen as a high risk by the provider.

The provider engaged with people who used the service by means of a corporate quality survey. The most recent of these had resulted in 84% of questions being answered positively. Areas of strength were identified

as safety and security, respect, and listening. Improvement areas were visits by senior staff, the office and wearing of ID cards.

The provider engaged with staff by regular care worker meetings and office team meetings. There were processes in place to recognise and appreciate occasions when staff went above and beyond, and the provider managed morale and motivation by tokens such as flowers, get well soon cards and birthday cards. When staff qualified for a long service award, this was recognised by a lunch and certificate.

The primary method for continuous improvement within the service was the provider's quality improvement plan. This took input from internal and external audits, complaints, and the registered manager's self-assessment which was refreshed every six months.

The provider had developed a computer based "dashboard" which gave the registered manager a visual display of certain key measurements of day to day performance. These included late or missed care visits, staff training, care plan reviews and staff supervisions and appraisals. At the time of our inspection this was showing 98% compliance with these measurements.

The registered manager had established working relationships with local authority commissioners and safeguarding teams. They also worked with Dementia Friends and Macmillan Nurses to improve people's experience of care and support.