Carewatch Care Services Limited

# Carewatch (Morpeth)

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

Carewatch Morpeth is a domically care service which provides personal care and support to people in their own homes. At the time of the inspection the service supported 362 people across Northumberland, Gateshead, Newcastle and North Tyneside. However, the majority of people lived in Northumberland. Carewatch Morpeth had recently moved their offices to a purpose built building in Ashington at the end of September.

We undertook this comprehensive inspection as we had received information of concern about the safety of people using the service, including missed planned visits and lack of staff.

At the last inspection in May 2017 were we found breaches of Regulation 12 and 17, relating to safe care and treatment and good governance. As medicines were not well managed and governance systems were not robust, with incomplete record keeping. We asked the provider to complete an action plan to show how they planned to improve the key questions: Is the service; safe, effective, responsive and well led to at least good, and to comply with all legal regulations.

This inspection took place on 20 and 28 November 2017. The first day of the inspection was unannounced with the following day being announced.

There was no registered manager in post. The last registered manager had left the organisation at the beginning of September 2017 and deregistered in October 2017. A new manager had been appointed and had taken up the role at the new location. 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.

We reviewed records of people's administered medicines at the service and were concerned with the findings. We found gaps, missing names and dates of when staff had been responsible for medicine administration. There was not always full or detailed information. Staff told us they had prepared their own records to help support people with their medicines as management had not provided them with medicines administration records. This meant we could not be assured that people were receiving their medicines as prescribed.

Risk assessments were not always in place, or lacked detail. Staff therefore did not have the correct level of information to keep people and themselves as safe as possible.

Accidents had been historically reported, the provider confirmed they conducted quarterly analysis on any accidents reported.

Initial assessments and care plans were not always in place. Those that were, lacked detail or had elements

missing or names were misspelt. At the last inspection, the registered manager said there was a backlog of incomplete care records. This was still the case.

Staff were aware of their obligation to report any safeguarding concerns and protect people from harm. Staff raised concerns with us during the inspection. They had previously received training in this topic and procedures were in place to support them.

Recruitment was ongoing with many of the office staff new in post, including the manager. The manager felt that there was enough staff in post to support people, although missed calls and rota issues made this difficult to confirm.

Although staff indicated they had an awareness of infection control and its procedures, people told us staff did not always follow safe practice. Gloves and aprons were not always available to staff to support this.

We could not confirm if people were always supported to have maximum choice and control of their lives or that staff always supported them in the least restrictive way possible. This was because information was missing. The policies and systems in the service did not fully support this practice as they were not robust.

Records relating to capacity and consent continued to not be fully completed or in place at all. This meant that we could not always evidence that the service was operating within the principles of the Mental Capacity Act 2005.

Staff had not always received suitable induction, training, supervision or appraisal with the provider to ensure they were suitably trained and supported to work with the people they helped. Evidence was missing and staff confirmed this area to need improvement. At the last inspection we recommended that dementia training be incorporated. The provider sent us evidence to confirm this was now part of the induction process.

The provider confirmed that quality officers who would have normally completed spot checks on staff working in people's homes had been precluded from doing this because of covering shortages in other areas of the service, including trying to get behind the backlog of care records which needed to be in place. We found spot checks had not taken place for all of the staff records we checked.

Records regarding the level of support people required were not always sufficiently detailed. This meant crucial detail could have been missing to support staff ensure that people received the correct levels of nutrition and hydration.

Comments about the service and its staff were mixed. People were positive about the care staff, but more negative about office and management staff. Comments made about one particular member of management were passed on to the operations director.

We were concerned about the lack of care plan documentation in place. The provider, in some cases only had information they had been supplied with by the local authority and had not completed their own assessment and care plan documentation. This meant there was a risk to people when unfamiliar staff visited as they would not necessarily know what level of care to provide.

The service was not reliable, with missed calls and timings of care calls were erratic. People we contacted were concerned about the number of missed, late and not fully timed calls they received. The local authority was extremely concerned and placed a member of their own care team at the service to support them cover

calls.

The provider had a complaints procedure in place, but this had not always been followed or complaints recorded and responded to as they should have. People told us they had found it difficult to contact the provider to make a complaint and some told us they had given up trying.

Quality assurance checks to monitor the robustness of the service were in place. However, these had not always identified the issues we had during the inspection or when they had they had not been followed up to ensure they had been addressed.

During service reviews, feedback from people and their relatives would normally be sought. However, as reviews had not always taken place this had not always occurred. The provider had contacted a number of people though to listen to their concerns in recent weeks but we were not given any evidence what action had been taken as a result of this.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, staffing, receiving and acting on complaints and good governance.

We also made two recommendations in connection with infection control and accessibility.

We sent a letter of ongoing serious concern to the provider stating our initial findings.

You can see what action we told the provider to take at the back of the full version of the report.

During the inspection we were contacted by the provider and informed that they intended to remove the location. This meant that the service in Morpeth would close down and people receiving care would transfer to another provider along with the majority of staff. Before this report was published, the provider closed this service on 18 December 2017.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

The administration of medicines was not managed safely. Risk assessments, including those in relation to personal risk were not always fully completed.

Safe recruitment procedures were not always followed. It was difficult to confirm if enough staff were in place as scheduling systems were not satisfactory.

Infection control procedures were not always followed.

Staff knew how to report any concerns they had in connection with the safeguarding of the people they cared for.

### Is the service effective?

**Requires Improvement**

The service was not effective.

We continued to be unable to evidence that the service was working fully within the principles of the Mental Capacity Act (2005) because records were not in place.

Written instructions regarding people's dietary needs continued to be insufficiently detailed.

Induction, training and support provided to staff needed to be improved.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

There were mostly positive comments made about care staff at the service. However the provider and office staff were criticised for their approach to the delivery of care.

We received mixed views about the privacy and dignity of people who received care from the provider.

The provider had not always recorded whether they had

considered assistive technologies for people with impairment.

People were generally encouraged to maintain their independence.

## Is the service responsive?

**Requires Improvement**

The service was not responsive.

Care records continued to not always be in place and where they were, they persistently lacked detail.

People reported the service as unreliable because of missed visits and late calls.

A complaints procedure was in place but had not always been followed and people responded to.

## Is the service well-led?

**Inadequate**

The service was not well-led.

People, relatives and staff told us they were unhappy with the management of the service. Although the provider had put additional resources in place, it was still proving ineffective.

The provider confirmed during the inspection process they intended to close the service and transfer all service users to another similar service in the local area.

Quality assurance systems were not robust and any actions identified had not always been followed up. Care records continued to lack detail or were missing.

There was no registered manager in place, however a newly appointed manager was now in post.

# Carewatch (Morpeth)

**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.

We had received concerns from a number of different sources regarding the service and a decision was taken to complete an unannounced comprehensive inspection.

This inspection took place on 20 November 2017 and was unannounced. The provider was unaware that we would be visiting the service on that date. We continued with the inspection on 28 November and the provider was aware of this. The inspection team consisted of two inspectors on day one with a further two inspectors and one expert by experience supporting on other days to make calls to people and staff. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us. We had already been contacted by the local authority commissioning and safeguarding teams before the inspection, as they wanted to share their concerns and views they had gathered from people using the service.

We contacted 29 people and their relatives by telephone. We spoke with the head of compliance, an operations director, the quality service improvement manager, an executive director, the manager, the deputy manager, two coordinators, two quality officers and a number of administration staff. We also spoke with five care staff at the provider's offices and a further five were contacted by telephone.

We reviewed a range of 22 care records, including records associated with medicines management. We reviewed information regarding the management of the service, including reviewing the information on 15 staff personnel files, service audits and other management information regarding the service.

Inadequate

# Is the service safe?

## Our findings

At the last inspection in May 2017, the provider was in breach of regulation 12, safe care and treatment. Medicines were not managed safely, care plans and risk assessments were not always available or completed correctly. At this inspection we found a continued breach of this regulation.
People told us that they did not always receive their medicine on time. One person told us, "I'm on strong painkillers and sometimes I don't get them on time." Another person told us, "They have missed some calls and I rely on them to give me my medicines."

We received further concerns from relatives and friends about the administration of people's medicines. A relative told us, "The girls [care staff] are pleasant when they come, but I want to say that the carers at the moment seem terrible. They leave the place very untidy and rush off and I've found tablets on the floor and they've signed for having given them." A friend of one person was visiting when we telephoned. They told us that they had also found tablets on the floor when visiting the person although records had shown all medicines had been administered.

Completed medicine administration records (MAR) were returned to the providers offices once a month. We checked a large number of these and found gaps in the majority of cases we looked at. This meant we could not be assured that people had received their medicines when they should have. Medicines that are prescribed 'as required' should have information included in people's medicine records to support staff on administration. 'As required' medicines are medicines which as normally only taken as the need arises, for example for pain relief. We found no records of any additional information available regarding 'as required' medicines.

Topical medicines refer to, for example, applications to the body surfaces of a selection of creams, foams, gels, lotions, and ointments. Detailed information was not available to staff to ensure they placed the medicine at the correct location on the person's body. The MARs we viewed simply stated the type of cream (for example) and that it should be applied am or pm. This was poor practice, particularly as people had received care from staff who did not know them well. This meant there was a risk that these medicines may have been misapplied in error.

Staff told us that in many cases they were going into people's homes to support them with medicines administration with no MAR chart in place. They said that if that happened, they had to use, "common sense" and, "look at the medicine boxes and use them." One staff member told us, "We have to fill MAR charts in sometimes when there is none there." We were able to confirm this from the MARs as the name of the staff member completing the form was sometimes written on the document. This did not follow good practice in preparing medicines administration records. A staff member told us, "Clients are not safe and looked after."

At the last inspection we recommended the provider continued to closely monitor the punctuality of calls. However, they had failed to do this robustly which had meant many scheduled visits to people's homes had not occurred.

We asked people and their relatives if they had been subject to any missed care calls. Comments included, " They've only missed about two or three"; "I've had two missed calls in the last two weeks"; "I've had two in the last two weeks, when they've not come in the evening"; "Just the once" and "We've had about six or seven altogether since September. When I phoned the office last week, they said there was no-one down to come."

We asked people if care staff arrived on time and comments included, "Sometimes they come 11 o'clock or 12.30 or 2.30pm and her time is 1.30-2pm"; "It depends. At the weekends, they never do (arrive on time). It can be anything from 15-20 minutes to over an hour (late)"; "No. At the worst it could be half an hour. On one occasion I got a double visit because the carer didn't know that I'd already been seen"; "Just lately, they've been a bit late"; "A miracle happens if they arrive on time!" and "No, they don't. They just arrive when they arrive. They were an hour late last week."

The length of the planned visits to people's homes were scheduled to enable staff to meet their needs. People told us staff did not always stay for the allocated time. People's comments included, "They're always rushing; I could choke for instance and they wouldn't know because they've gone"; "No (don't stay for allocated time). Sometimes they have to go because they have loads of work to do and they haven't got the time to do it"; "They rush in and rush out. They just put my breakfast in front of me and go" and "Well, sometimes they're away quick. They seem to be playing catch-up."

Overall people and their relatives told us that staff often missed calls, arrived at different times to that expected and did not always stay for the scheduled time. People also told us that they were rarely contacted to inform them of any changes and most people we spoke with said it was extremely difficult to get in touch with the office to report their concerns. One person told us, "The carer's are okay, but the office staff never get back to you."

The provider did not have a robust system to monitor missed calls. We were concerned to find the provider was unable to tell us how many scheduled visits they had failed to attend on a certain date. For example, when we asked how many missed calls there had been on the evening of Monday 20 November 2017, the manager told us two. Another staff member provided us with a further two names, the local authority confirmed that a further three calls had been missed. Staff were meant to log in and out of people's homes using a 'tag' system via the work mobile phone. However, not every person had records in place, some staff had no phones to use this system and the scheduling of calls was in the process of review. All this had led to calls being missed and the provider unable to determine which calls had not been attended unless either people called the office to report a missed call or a staff member reported a missed call. This left people at risk of not receiving their planned care.

On call systems were in place but reports had been made by staff and by people and their relatives using the service that telephones were not always answered. One staff member told us, "You can ring, but the answer you get is not very good and not helpful at all. I phoned last week and wanted some help and got none. I ended up ringing round other staff." Another staff member said, "We are so worried about people and the missed calls, last week we went round and checked people had received their calls. It's not right and needs looked into. No one [provider] seems to be listening to us [staff]."

Environmental risk assessment to identify any risks to staff working into people's homes including hazards such as tripping, poor lighting or pets present in the home were not in place for every record we viewed and the provider confirmed this to be the case. Two people, who's records we reviewed had dogs but there was no mention in the risk assessment about these. Risk assessments in relation to the everyday had not always been routinely completed. For example in connection to falls or the use of particular equipment. One person

was in daily use of oxygen but no risk assessment was in place to protect them or the staff member. Another person was at risk of malnutrition due to poor nutrition. We found no risk assessment or care plan in place for this person.

These are breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

The manager felt that there was enough staff to meet the needs of the people they cared for. However, they told us, "I think we do have enough staff but until the rota's are sorted out it is extremely difficult to prove. We have staff who don't do so many hours but because the rota is all over, I could not say for definite, but I do think we do from what I have seen." We were not able to confirm this, as robust processes were not in place and many missed calls had occurred. The local authority confirmed that they had supported the provider with over 20 calls from the previous weekend as they did not have staff to cover.

Recruitment was an ongoing process with many new staff in place, including coordinating officers, quality officers and care staff. Staff personnel records were limited in detail and most were disorganised. We were told by the manager that recruitment checks had been made, however, the provider had not always recorded the information to confirm this was the case. For example, Disclosure and Barring Service (DBS) reference numbers were not always recorded or the date these had taken place. The DBS carry out suitability checks of applicants to establish if they are appropriate to work with vulnerable people, which helps employers make safer recruitment decisions.

The manager assured us that the providers IT system could provide DBS details. However, when we asked the provider to send us this detail, the record had been completed manually and showed that many DBS checks had not yet been completed, or were in need of renewal. Three staff members who were currently visiting people in their own homes had no valid DBS on record, although the provider assured us that their records had been archived with this information as they were "older more experienced staff, who had been with the organisation for some time". From the information held on the provider's IT system, we confirmed these staff had completed an induction programme at the end of 2016 and early 2017 so we deemed these as newer staff. After the inspection, the provider confirmed that risk assessments had been conducted for these staff and new DBS checks obtained.

Office staff tasked to carry out HR (human resource) checks on potential or current staff had received no training to support this role. Which meant they were not trained and skilled to ensure best practice was being followed.

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

It was noted that on day one of the inspection, four new scheduling officers were in place. However, on the second day of the inspection, two had resigned. The service was utilising other office staff to cover these tasks, but this was proving difficult.

People felt safe with the care staff who visited them in their homes. Comments included, "Yeah, they're all really professional and all really helpful"; "Oh yes, I've been fortunate with the girls [care staff] I've had"; "Oh yes, yes, I've made quite a few friends"; "Yes, I do. She's a very nice girl [care staff]; I'm very happy with her"; "Yes, aye they're alright. They're canny (nice). They seem to know what they're doing. One or two of them stand out anyway" and "Yes, they're so friendly and they'll do whatever you want."

Relatives confirmed people's comments about feeling safe and said, "Well yeah, he's not had no bother"; "She's [person] known them about a year now and they get on well with her"; "Yeah, because they're there for her and they support me" and "Oh yes. [Person's name] is happy, so I am."

Staff had previously received training in the safeguarding procedures. Policies and procedures were in place to safeguard people from abuse. Staff had access to a safeguarding policy that provided guidance on the types of abuse that can occur in care settings and how staff could report them. The staff we spoke with had no concerns with raising any issues they had. This included reporting to the inspection team how concerned they were about the welfare of people in recent times. One staff member said, "People are at risk. Some are just not getting the calls they should. In fact we (a number of care staff) popped into check people had received their calls the other day because the rota isn't working and we know the rounds... it was the only way to check everyone was ok. It's really bad. We have reported our worries, but no one is doing anything. They say they are, but nothing happens". The provider had made appropriate referrals to the local authority safeguarding team in relation to the missed calls where people had been at risk because staff had not attended to their planned visit.

Accidents and incidents had historically been recorded and we saw no evidence of recent events. Safeguarding concerns continued to be logged and reported to relevant agencies.

Staff had an awareness of infection control procedures. They told us they had access to personal protective equipment, such as aprons and gloves to use for cooking or other personal care procedures. However three staff said that they found it difficult in recent weeks to obtain supplies. People we spoke with confirmed that staff had told them they had 'trouble getting hold of supplies'. One relative also said, "They come in and often don't have gloves and the majority don't wear pinnies [aprons]." Another relative said, "Sometimes they don't use gloves and they never wear aprons." The manager was not aware of any issues with equipment and said they would look into the concern we raised.

We recommend the provider reviews its policy around supply of equipment to staff to ensure it follows infection control procedures fully.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection in May 2017, the provider was in breach of regulation 17, Good Governance. Records did not always reflect that the provider was working within the principles of the Mental Capacity Act (2005).

The 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.

Records continued to not show that the provider was working within the principles of the MCA (2005). Documentation in relation to people's mental capacity continued to not always be completed. When we spoke with staff, they appeared to be aware of the support people required and what their capacity to make decisions themselves was. However, this detail was not always recorded in people's records which meant we could not check the information we had been provided with verbally, was correct. It also meant that any new staff providing care calls would not necessarily have this level of detail.

This was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good Governance.

We asked people and their relatives if they thought care staff were well trained and able to provide them with effective care. Comments were positive and included, "I think so. I have asked one of them what training they had for the job (was happy)"; "Well yes. She's only 18 years old but she's very good and I wouldn't like to lose her. She helps me with my shower"; "Well…I don't know the answer to that one. They're always rushing; I could choke for instance and they wouldn't know because they've gone. They used to stay until I was ready [The person did not think the carer staff understood their needs)"; "There's one or two who are really good. There is one or two young uns…they'll make good but they're a bit slow yet"; "Yeah, yeah (well trained). They've been working with [person's name] for a long time"; "Yes. Mam has Alzheimer's, but they know what to do" and "Yes, they're very good."

However, we did receive less positive comments which included, "I don't think so. She has complex needs and the girls [care staff] just don't know how to handle her" and "Some of them are great, but some are slap-happy."

Records showed training which the provider deemed as mandatory and refresher training had not been completed in all cases. For example, administration of medicines, moving and handling and infection control. Some staff had expired training certificates in their personnel files and no evidence to show continuous development. The provider's IT system which showed staff training indicated different dates of training to those dates on staff files. We were not able to confirm which dates were correct or agree confirmation of attendance by staff. This meant the provider's system for ensuring staff skills and knowledge

remained up to date, so they could meet the needs of the people they supported, was ineffective.

At the last inspection we recommended that training to meet the person centred care needs of people living with dementia was provided to all staff. However, we saw no evidence to suggest that this had been completed for any member of care staff. The provider sent us a copy of their induction training which had been updated to include a dementia awareness section.

Staff had received induction and shadowing opportunities, but this was not robust. One staff member told us, "There are staff out there who should only be shadowing but they are doing calls themselves because there is no staff to do them or they are asked at the last minute to go somewhere." Another staff member said, "They [provider] are using staff who should be shadowing for double up calls without the experience." We noted that the provider had an induction booklet based on the principles of the Care Certificate.

A supervision and appraisal system was in place and we saw historic records in staff personnel files of supervisions held with their manager. However, these meetings, to discuss staff member's role, understanding and people they supported had not been held regularly. From the records viewed, the most recent date we confirmed that an observation had taken place was in 2016. Staff told us they had previously received supervision, but nothing in recent times. One staff member told us, "I feel totally unsupported at the moment, it's a shambles." Another staff member told us, "I don't like working here at the moment. No one seems to know what is going on. We don't get any support and it feels like you're on your own." One member of staff who recently transferred into the organisation from another, told us that they had started work just under a week ago and had yet to meet with management or their direct line manager. They told us that it was only by their request that they were now having a meeting that day.

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

People continued to be supported with eating and drinking when this was part of their care call package. People told us that care staff supported them with meals as they required. Although issues had arisen when missed calls had occurred, people were satisfied that staff completed this element of the care call well when it was required as part of their care package. We found that written information to help staff support people with their dietary requirements was not always available. The operations director said they were in the process of updating people's records to ensure this level of details was available to staff. This meant we could not be assured that staff had the level of detail they may have needed to provide people with their correct dietary needs. Including, for example, those people who may have had more complex requirements in connection with nutrition, such as people with diabetes.

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

We saw evidence people were supported to access healthcare appointments as necessary. People gave us examples of how staff had supported them with healthcare appointments and confirmed that staff would support them if needed. Comments included, "I walk with crutches and the staff help if I've got any appointments"; "Yes, they would. I did have a fall and the carer's called for an ambulance"; "I would presume so if my family couldn't do it"; "They have called the GP for me when I was poorly" and "Yes, they would and if they couldn't do it themselves, they'd phone me." When we looked on the providers IT system, we saw that staff had been in touch with the office to alert them to health care concerns they had about an individual. This was recorded in daily logs. We also overheard one member of care staff when they called the office to seek advice and discuss concerns they had about one person.

Requires Improvement

# Is the service caring?

## Our findings

We received mixed views about the caring nature of the service and its staff. People and their relatives thought that the vast majority of care staff were kind and caring and were passionate about providing them with good quality care. However, they did not hold the same views for office staff and the provider in general. Positive comments included, "Yes, they're very caring people (care staff). [Person's name] seems to think they're friends"; "They (care staff) always check how I am and stuff"; "Two I'm very impressed with. I've never had any rudeness"; "Yes, yes. For an 18 year old girl she's very good. We have a bit chat and she's very kind"; "A couple of carer's in particular were very, very good. There are a lot of negative things to say about the service, but I must say, two more experienced carer's were extremely good. [Person's name] is very difficult, but they won her confidence" and "Oh, they're (care staff) very kind and caring towards [person's name]. They haven't been nasty or anything."

Negative comments included, "Some are, some aren't (caring). Some can be abrupt and not spend time with me. It seems a one-sided affair"; "I don't think the office staff care about us at all. They don't answer the phone, are rude when they do and don't seem to take my concerns seriously"; "That boss at the office is hopeless and rude, pointless speaking with her"; "Office staff have been abrupt before. When I eventually got through, I felt like I had been told off for calling" and "I have been trying to get through to one of the supervisors for over a week now. It's hopeless; you might as well not bother. You get more information from the staff that come out…mind, they seem to be in the dark too." We passed some of the specific comments in relation to one manager on to the operations director, who noted these concerns.

People told us that staff had encouraged them to remain as independent as possible. One relative told us, "Yes. They'll make suggestions to encourage him to do things such as make his bed and do his dishes."

Staff told us they knew it was important to maintain dignity and to respect the people they cared for. However, not all the comments from people and their relatives in relation to dignity and respect were positive. Comments included, "No, they don't. They leave the doors open"; "There are a couple who don't. I can't explain why [but felt nothing serious]"; "Some carer's do; it depends on their mood on the day"; "When they wash me, I have a big bath towel and I have that wrapped round me. They always put the screen round the shower"; "Oh yes, yes, they do (maintain dignity). When he (person) has a body-wash, they use a towel and things and will look away at the appropriate time"; "Yes, they do. Sometimes he'll forget to put his dressing gown on when answering the door and they'll say 'run up and put your trousers on'" and "Oh yeah. He'll only allow them to do certain things and they respect that otherwise he would get upset and agitated."

We saw from care records that a number of people had requested that all of their visits, to provider personal care such as bathing or showering, be provided by all female or male calls for example. The provider explained that at this current time, this was not always possible due to the difficulties within the rota system. One relative confirmed this to be the case and said, "[Person] has asked for male staff, but it is rare this happens because of difficulties with staff at the moment." Another relative told us, "Oh no, no, I get Tom, Dick and Harry. We were asked whether [person's name] wanted male or female and he requested male. Since then we've had 3 females instead of males." At our last inspection this was also the case and

continued.

Assistive technologies are products and services that empower disabled people to become more independent. Under the Equality Act 2010, assistive technology is recognised as a 'reasonable adjustment' which should be made available to prevent discrimination in a wide variety of contexts. On two people's records we examined, we noted they had visual impairment. We were not made aware of any changes to normal procedures which may have assisted these individuals further. Normal procedures were in place and there was no record to show that the provider had considered their disability to ensure their independence and ease of access was appropriate. There was no mention of any assistive measures taken to support them, for example bolder print on paperwork.

We recommend the provider ensures communication barriers for people are considered as part of their normal care planning process.

People's confidential information was not always stored safely and securely. Approximately 50 local authority care records were in a pile on the floor of the manager's office. This 'pile' of records were in the same place throughout our inspection visits with no evidence of being locked away securely. We also found records in a filing cabinet which we were told were old records, but which in fact were current 'clients' of the service.

We saw no evidence to suggest that any person was using an advocacy service as many had relatives; friends or neighbour's to offer additional support. One staff member told us they knew what an advocacy service was and would contact the office for advice if a person they cared for required additional support. An advocate supports people to express their views and helps to protect their rights.

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection we were concerned about the lack of care plans and person centred information available to staff to allow them to support people in their own homes. We deemed this to be a breach of regulation 17, Good Governance. At the last inspection the registered manager at the time said there was a back log of care records that needed to be completed. This continued to be the case.

We checked the providers IT system and also hard copies of people's care records. We found that they were both lacking in detail, with some people who had been supported for over four months with no care plans at all and others with limited care plans in place having had no review for over a year. The IT system was, in many cases, limited to the information it recorded. We also found that the only record the provider held in hard copy in many people's files was from information received from the local authority and they had not completed an assessment, care plan or any risk assessments in relation to the care offered.

We found the names of people using the service were not always recorded correctly. For example a care plan from the local authority had a person's name spelt one way and the provider had recorded it another. When we checked with the individual, it was the local authority spelling that was correct.

We asked people and their relatives if they had a care plan in their homes or if they had been involved with its planning. Comments included, "The carer's don't seem to have any information on the client"; "I have one somewhere, but I've never read it in detail"; "No, I don't think I have. I've never had a folder. Neither the girl that comes nor me knows why. She brings a piece of paper with her and she signs it when she's been"; "I can't remember (having a care plan)"; "I don't really know. I've never seen one"; "Not that I know of. I have got a folder but it's only got the times that they visit"; "No, I don't think I do. They haven't got that going yet"; "No, nobody's come out and asked what his problems are and what medication he's on"; "No. Someone came just last week to ask who his dentist was and different kinds of questions, but I haven't got anything back [been receiving care for 8 weeks]"; "I can remember them asking me questions" and "My social worker did it." This confirmed that care plans were not in place for every person using the service and they had not all been involved with its preparation when they were.

Staff had received limited information about people on their security protected works mobiles. However, detail was limited and did not include all the information they needed to support people fully. For example, one person displayed behaviour's which could have challenged staff. Staff were not provided with detail in connection with this to keep both them and the person safe. Another person used oxygen on a daily basis but this detail was not passed on to staff supporting the person. Although they had not come to any harm, this detail was crucial to their wellbeing.

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

People and their relatives told us that they had different care staff and there was no continuity in rota systems in place. One relative told us, "They [provider] are not responsive to our needs at the moment."

Comments included, "Most days I've got somebody different"; "I get quite a variety of people"; "I have different ones"; "No, you get different ones. You might see them say twice a week"; "This last few weeks it seems to be between three of them"; "Different ones come different days"; "We did in the beginning but not now. It's hitty-missy now"; "No, they're all different now, you know. They come from all over the place, you know."

People and their relatives also told us they were given rotas detailing which staff member would be attending to their care visit up until approximately one month before our inspection, but that they not longer received it. Comments included, "I used to (get a rota) but it stopped about 4 or 5 weeks ago"; "No, I don't know which one (care staff) of them is coming"; "No, I wished I did because it's a big help"; "You never know who's coming. On the sheet we get it says for your time, 'unallocated'"; "No. He [person] just knows someone will come every day to check up on him" and "In the beginning she [office staff] used to (provide rota) and then it just stopped. We haven't a clue who's coming until they get to the door."

As people often did not know who was allocated to their care call, they told us they were often anxious. One person told us, "I don't like not knowing who is coming. How would you like that. You are vulnerable on your own. They [provider] should remember that."

People and their relatives we spoke with were aware of how to complain, although not all of them had information in their homes to explain the process. We asked if they had any cause to complain now or had in the past and what had been the outcome for them. Comments included, "Just once (complained), about one of the managers in the office. It could have been dealt with better"; "I haven't made any complaints, but I would complain about cleanliness and timing (issues now)"; "Just about the timings, but it's never been sorted (issues now)"; "Just about when they don't turn up. I'm not happy with how the office deal with it, no; it's bad organisation (issues now)"; "Just about the timing and the other complaint is about having a female (have requested a male worker), but they've just ignored what I've said(issues now)"; "No (complaints), I haven't, but [person's name] can nit-pick at times" and "I made a complaint when they used a cold shower once, but I never heard nothing more."

There was a complaint procedure available but not all of the complaints we were told about were logged on the providers IT system or in paper records. The new manager was unaware of these as it was before she had started working for the provider. We were unable to establish why these complaints had not been followed up as all management had been replaced. Many of the recent complaints we had received from people we had spoken with were unprocessed as they had also been unable to contact the provider.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

A copy of compliments was held at the service. These included praise for individual carer staff; which was then passed on to them by senior staff. Although we saw no recent compliments had been received.

We were not made aware of any person who was receiving end of life care so we were unable to confirm if the provider had ensured they were comfortable, remained dignified and were supported with a pain free death.

Inadequate

# Is the service well-led?

## Our findings

At the last inspection in May 2017, the provider was in breach of regulation 17, Good governance. Records were not satisfactorily maintained in relation to care plans, risk assessments, and the Mental Capacity Act 2005 (MCA) and robust quality assurance systems were not in place. These shortfalls continued.

During the inspection process we were informed by the provider of their intention to close the service and transfer the people using it to another provider by 18 December 2017.

There was a new manager in post who had taken up the post in the last five weeks. They were not yet registered with the Commission.

During the inspection we asked the provider to send us information about the number of people they supported who were 'high risk' due to their complex needs. We had also, at the same time, asked the local authority for a copy of their high risk 'service users'. The local authority provided us with names who did not appear on the provider's list. We asked the provider why that was and they were not able to provide us with an answer. After the inspection the provider told us, "The Local Authority did not share their list of high risk service users with us, we RAG rate our service users on criteria such as diagnosis, and do they live alone, therefore criteria may have varied and given different results." When we compared the list, we were able to confirm that some people should have been on the providers "high risk" list. A RAG rate is a red, amber and green scoring tool to help providers decide on the level of risk to individuals.

During this inspection we identified a number of shortfalls in the care people received. Some people had information in place giving an overview of their needs which been provided by the local authority when they had commissioned the care package. However we did not, in majority of cases, see that initial assessment, care planning and risk assessments had been completed by the provider. We found other care plans which had not been recently reviewed in line with the providers 6 month policy, some over a year. This meant in many cases staff were going to visit people in their homes with little information and no care planning or risk documents in place to refer to.

Staff records and the care records of people were not kept in good order. Some staff records we asked for had been archived and we were not able to access the information we requested. For example to check the Disclosure and Barring Service details for three staff or training records for others. Care records were not always in place and lacked detail. We found a file of approximately 50 people's local authority care planning documentation in the manager's office which had not been placed in files or recorded on the providers IT system. This information was also not fully available to staff. We also found seven people's care records in a filing cabinet in another room away from where they were normally stored, which management were not aware of.

When we arrived at the service we asked the manager and operations manager how many people they cared for in their own homes. We later asked the provider to send us a list of people split between those privately paid for and those funded via the local authority. We were given a variance in numbers. This meant

the provider did not have robust systems in place to understand the number of people they supported throughout the area.

We requested lists of staff with contact telephone numbers. We waited for this information for a number of days. This showed partly the lack of ability of the current staff to retrieve information from the organisation IT system.

We were informed that care calls to people were being scheduled only 24 hours before they were due to be attended. This meant that people and care staff were unaware of who would be covering calls until the last minute and this had led to missed calls and office staff struggling to cover unallocated care calls. The provider had brought staff from other areas of the business to support the branch in Morpeth in the two weeks prior to our inspection. This included, scheduling officers and IT staff. The new manager told us they were frustrated and said, "It's too little too late though." Although the provider told us that missed calls were at a minimum and that rotas should have all been in place by the end of the inspection, we found this was not the case. Staff we spoke with throughout the inspection (including the end) told us that double up calls were not always in place and calls were still being missed. The local authority confirmed this.

The provider had no robust system in place to monitor missed calls. We asked the provider on the evening of our first inspection visit, Monday 20 November 2017, how many missed calls there had been that day. Initially they said two and gave us the names. We then asked office staff and one staff member said there had been another two missed call and the names were in addition to the two already given. Another staff member said there had been a further two missed calls. The local authority commissioning manager sent us a list of a further two missed calls that day. Meaning in total there were eight missed calls which we were aware of. We asked for a further number of dates and missed calls and these did not correlate with information we received from the local authority; who had been contacting people to check they were safe. The provider was not able to identify missed calls unless staff informed the office or the service user called.

People had systems in their homes (but not all) in the form of a 'tag' to allow staff to log in and out of calls. The manager showed us a daily report produced centrally which was sent to her every day. This showed staff log in/outs by staff name but did not give details of the person they were visiting. Some staff showed as not fully logging in/out. The manager confirmed that at that time they had no system to show numbers of missed calls. However the provider told us they were in the process of adding software to the current system to allow them to flag up when staff had not logged in and this was to be in place by the end of week. At the end of the inspection (over a week after the date indicated, this was still not in place.

The local authority were supporting the service with their team of care staff to try and ensure that any unplanned or missed calls were attended to and had based a member of their care team within the provider's office base to support the provider.

Minutes of staff meetings were not recorded and the provider confirmed this, although we were able to confirm that a recent meeting had taken place. Staff told us that meetings were not held often and communication was poor. Staff had been recently transferred from another service as Carewatch had taken over a number of care packages from another provider. One transferred member of staff told us they had been at work nearly a week before there had been a meeting with senior staff. They said this had only been arranged because one of them had complained. They said they felt let down and isolated in their role.

An equality and diversity policy was in place, however not all staff were aware of the protected characteristics. There was no evidence to show that equality and diversity had been embedded into practice at the service, such as in supervision or meetings for staff. We were unable to confirm if staff were working

within the principles of equality and diversity. There was also no evidence to show they were any equality and diversity priorities were in place to protect people and staff from discrimination.

Staff were not all aware of how much supervision, appraisals and observations they should be subject to. The majority of care staff and a number of office staff we spoke with felt unsupported by the management team.

We were informed by the provider's head of compliance that the quality audits which should have been in place, included those in connection with medicines, daily logs, staff files and finance. We found that medicine audits were lacking in completion. The manager (both previous and new) had not always signed these off as they should have to check they were satisfactory. When issues were identified any action taken was not always recorded. The Quality Service Improvement Manager confirmed this. We were told that 10 percent of records should be checked each month, however this had not occurred. Audits which had taken place had not highlighted the shortfalls we had identified during this inspection. For example the medicines audits had not uncovered the areas of concern such as incompletion and lack of information that we had during this inspection.

Staff files had not been audited but were in the process of being completed at the time of the inspection. Senior staff told us that they had identified a number of pieces of information missing from particular staff records, including training records and personal checks and were in the process of rectifying these.

We saw no evidence of any financial checks completed as not copies were available in the office. We were told these were in people's homes. Although no copies of older checks were available either.

There had been no accidents and incidents recently reported, but historic events were logged. We asked for any information to show how accidents would be monitored as part of quality assurance or to look at any lessons learnt. We found no evidence to confirm how any analysis would take place. The manager told us they were not aware of any analysis process and this was confirmed by the head of compliance. However, after the inspection the provider confirmed that quarterly analysis of accidents was undertaken.

Feedback systems continued to be in place from the previous inspection. Staff also told us that during reviews they gained feedback from people and their families. The provider told us they had contacted people recently but there was no evidence given to confirm the conversations taken place or any actions which had been agreed.

These are continued breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

We asked people what their views were of the management of the organisation. Comments included, "It's absolutely shocking apart from one or two in the office"; "I think the management is appalling. I had a letter last week giving me a contact number which I tried several times and I had to leave a message, but no-one from the office rang back, but social services did ring later in the week"; "Not a lot at the moment, but we need to give them a chance to sort it out"; "We've only had them [Carewatch] a couple of weeks and the first week was a mix-up, but it's getting better now"; "It's badly organised at the office end, but the carer's are great" and "Not very much."

Asked if people or relatives would recommend the service to others, remarks were mixed. Comments included, "No, just because of how shocking it's been. The girls are lovely, but the management of the rota's and things, is terrible"; "No, because they're late. There's all sorts of muddles"; "Oh, I think I would, yes"; "As

far as I'm concerned and the treatment I've had, I would be happy to, but I have heard what's going on around (not positive"; "Yeah. It could do with being sorted out a bit, but once sorted, I think it could be a good service"; "As far as I'm concerned, I've always been happy and I've never had any trouble"; "Not yet"; "Yes, definitely. Well, the carer's definitely"; "Not at the moment."

The management team told us recruitment had been a large undertaking recently. The registered manager, scheduling officers, quality officers and some of the staff care team had left the organisation. New staff had been appointed but as they did not know the systems in place, it was proving difficult for them to manage effectively. The manager told us, "They [provider] have sent staff to support, but it's too little too late."

Communication was poor. People told us that they were not told of any changes occurring and that it was difficult to get in touch with the provider. Comments included, "A couple of the management staff can be abrupt"; "I'm not very impressed with the office girls"; "There doesn't seem to be any co-ordination between staff and the carer's"; "No, nobody lets me know (about any changes to times of calls/missed calls)"; "If I've rung, I don't get an answer"; "No, they should ring us. I've told them to, but they don't"; "It's hitty-missy. A couple of the lasses are really helpful, so I only speak to them"; "I was able to get through, but they didn't (office staff) know what they were talking about"; "No. It's always engaged. I've not been able to get through, more so in the last three to four weeks"; "I have got the number now, but I had to ask for it" and "It was quite hard to get through, but I've managed it now."

On 22 November we were made aware by the local authority in Gateshead that Carewatch were giving notice to approximately 15 people. We were then informed on the 28 November by the local authority in Gateshead that the provider had changed their mind. This was after people had been informed. The provider representative told us that there had been a 'miscommunication' and this should not have happened. We later found out that people had been very distressed by this 'miscommunication'.

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<br><br>Procedures for the safe management of medicines were not in place. Risk assessments were not always in place.<br><br>Regulation 12 (2) (g) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider had not acted upon complaints it had received or recorded fully those it had with any actions taken.<br><br>Regulation 16 (1) (2) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Records were not maintained to safe and suitable levels, including all those in relation to the care planning process. Quality assurance systems were not robust.<br><br>Regulation 17 (1) (2) (b) (c) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not received appropriate induction, training or support. We could not confirm if |

there were enough staff in post to support people appropriately.

Regulation 18 (1) (2) (a) (b)