Morris Social Care Limited

Carewatch (Bristol)

Inspection report

Morris Social Care Limited
CareWatch Bristol
Inspection report
2 Russell Grove
Westbury Park
Bristol BS6 7UE
Tel: 0117 942 4848
Website:

Date of inspection visit: 14 and 17 November 2014
Date of publication: 06/02/2015

Ratings

Overall rating for this service	**Inadequate**
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**

Overall summary

The inspection took place on 14 and 17 November 2014 and was unannounced. At our inspection in August 2013 we identified breaches of regulations relating to care and welfare, how staff were supported and how the quality of the service was managed.

During this inspection we looked at whether improvements had been made. We found that improvements still needed to be made in relation to care and welfare, supporting staff and how the quality of the service was managed.

Carewatch (Bristol) provides personal care to people in their own homes and support with household tasks such as cleaning and shopping. At the time of our visit there were around 70 people using the service.

Summary of findings

The inspection took place on 14 and 17 November 2014 and was unannounced. At our inspection in August 2013 we identified breaches of regulations relating to care and welfare, how staff were supported and how the quality of the service was managed.

During this inspection we looked at whether improvements had been made. We found that improvements still needed to be made in relation to care and welfare, supporting staff and how the quality of the service was managed.

Carewatch (Bristol) provides personal care to people in their own homes and support with household tasks such as cleaning and shopping. At the time of our visit there were around 70 people using the service.

There was no registered manager and there had not been one for over 18 months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. There was an acting manager who was appointed to the post in August 2014.

The registered provider, who is also the nominated individual, was unable to fulfil the requirements of their role for personal reasons.

Although people said they felt safe we found that the agency was not providing consistently safe care. People regularly did not receive their planned visits from care staff at the required times and on some occasions not receiving visits at all. This directly impacted on the safety and welfare of a number of people who used the service.

People had an individual plan setting out the support they needed and how this was to be provided. Some people's support was not provided as detailed in their care plans. Some people's needs had not been regularly reviewed. This meant people did not always receive support in a way that met their needs. For example one person told us their morning visits frequently took place so late their relative had to stay in bed and could not get up at the time of their choosing.

People told us the care workers treated them with kindness and respect. Staff had got to know many of the people they supported well. They also demonstrated an understanding of the needs of people they regularly visited. However staff and people who used the service told us there were often times when they had to assist people who they did not know or only knew slightly. This impacted on the ability of staff to provide a personalised service to people.

The provider had a system in place to ensure safe and suitable staff were recruited. New staff completed training before working unsupervised for the agency. The staff understood their responsibility to protect people from potential harm or abuse. They knew what action to take if they were concerned about the safety of a person using the service.

There had been an increase in late visits and missed visits to people by care workers over the previous six months for a significant number of people. The online monitoring system known as CM2000, which is a system put in place by the Local Authority recorded there were recent and regular occasions when some people were not receiving a safe service.

The lack of reliability of the service people received meant it was not fully effective as people's personal care needs were not always met.

People reported a lack of effective communications from the office and the staff there. People told us they were often not given the information they asked for if a care worker was running late for a visit. Some people also told us they were rarely contacted with an explanation for why a visit was late or missed. The majority of people said they were given unhelpful responses, such as being asked to remember there were people who were much sicker than they were. One person also reported how they were often called "love" or "darling" when they rang the office, and they found this patronising.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the number of staff, a lack of staff supervision and monitoring the quality of the service. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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. Staffing numbers were not always appropriate to meet the needs of people who used the service. There was not enough staff to ensure people received a consistently safe and reliable service.

Appropriate action was not always taken in response to incidents to maintain the safety of people who used the service. This was in relation to late and missed visits.

There were processes in place to help protect people from the risk of abuse. Staff were aware of procedures in place to keep people safe. They knew how to report abuse if they thought it had occurred.

There was a procedure in place to guide staff to prompt people to take their medicines when they needed them. Staff had not done recent training to ensure they knew how to do this safely.

Is the service effective?

Requires Improvement

The service was not effective**.** People were not always supported with their needs based on their plan of care. This was because a significant number of people who used the service were experiencing a regular pattern of missed and very late visits.

People's needs were not always effectively met, because of the inability of the agency to ensure people were provided with the visits they needed at the times required to provide their personal care.

People were supported by staff who had some awareness of the Mental Capacity Act 2005. The staff knew how to promote people's freedom and protect their rights.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. Care staff were respectful of people and were kind and caring in their approach. However some people reported they had found some office staff, "dismissive" and "patronising" to them when they rang up.

People were not fully involved in making decisions about their care and the support they received. The reliability of the service meant people's preferences made about their care, such as the time they wanted support, were not always met. Visits to people were regularly inconsistent and the timing unreliable.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not responsive. Care plans were in place outlining people's care and support needs. Staff had an understanding of people's support needs and how to meet them. However most people we spoke with were not guaranteed a consistent or reliable personalised service.

There was some positive feedback from people who told us when they saw regular care workers they understood how to support them. However many people told us they never knew who was going to turn up when their visits were due. They said they had to tell staff who did not know them how to provide the care and support they required.

There was a system to receive and handle complaints or concerns. However a number of people's complaints were not responded to promptly. The provider's complaints information showed some significant delays in responding to complaints.

Is the service well-led?

Inadequate

The service was not well led. People were put at risk because systems for monitoring the quality of the service were not effective. Staffing levels were not assessed based on people's needs. This meant there were not always enough staff to carry out the visits people required.

The service has not had a registered manager for 18 months and there was an acting manager in post. The staff reported office staff were available for assistance if they needed advice. Staff also reported their morale was low because of the lack of management support.

Systems to monitor the safety and quality of the service were not effective and action was not taken to make improvements.

The quality of the service was not checked regularly to find out if people were happy with the service they received. The provider did not ask people their views of the service to find out if it was safe and suitable for them.

There was a system available that could be used to seek the views of people who used the service. This was either by telephone or by face to face interview. However the system was not being effectively used.

Carewatch (Bristol)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on Friday 14 November 2014 and Monday 17 November 2014 and was unannounced. The inspection was carried out by two inspectors.

At the last inspection on 5 August 2015 the service was not meeting the regulations. These were relating to the care and welfare of people, lack of staff support and concerns about the monitoring of the quality of the service

During our inspection we went to the location office and spoke to the acting manager, the compliance manager and six members of staff. We looked at six people's care records, the records for six staff, and records relating to the management of the service. These included staff training and induction records, five people's medicines records and quality assurance information.

We visited two people who used the service and one person's relative in their own home. After the inspection visit we undertook phone calls to 11 people who used the service.

Inadequate

Is the service safe?

Our findings

When we inspected the service in August 2013, we were concerned about people's care and their safety because frequent late and missed visits by care workers meant they received unsafe care. The provider sent us an action plan which we had asked for. In their action plan they told us how they would make improvements by the end of November 2014. At this visit, we found people's care and safety was put at risk by frequent late and missed visits by care workers

There were not always enough staff available to ensure people were safe. For example if a person needed two care workers to assist them with their needs, the office staff planned and booked two care staff for that particular visit. However we had been told by a local authority before our visit that there were times when only one staff member visited the person. One person receiving a service also told us this and said they needed two staff to meet their full range of needs.

People told us they were not always satisfied with the staffing levels. They appreciated the care they received from the staff who visited them however did not always receive a consistent service. This was because there were occasions when their needs were not being met. This was when people had not had the planned visit from staff or it had happened considerably later than they needed. Over the previous six months and longer there had been an increase in the number of late visits and missed visits. Feedback from people we spoke with and from relatives showed how this had directly impacted on people's care. One persons' relative said their relative had to stay in bed when care workers did not turn up at the allocated time. Another person's relative said their relatives had been distressed on a recent occasion when a care worker had not arrived for a visit at the required time.

This was confirmed by the online monitoring system CM2000. This logged and recorded the times and duration of visits to people whose care was funded by the Local Authority. The system showed a consistent pattern of late and missed visits for the majority of people who used the service. For example 46% of one person's visits over a month were outside the agreed times. For another person 35% of their calls were outside the agreed times. For the period from 1 October 2014 to 31 October 2014 the CM2000 report showed that there were 5,324 visits that took place of these 2027 were early or late (620 were early and 1407 were late). This was 38% of all visits due to take place. There was no evidence that appropriate action had been taken in response to these incidents to maintain the safety of people who used the service.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

Staff were aware there was a procedure in place to guide them to prompt people to take their medicines when they needed them. However the staff had not done recent training to ensure they knew how to do this safely. This was also confirmed by the staff training information we viewed.

Risks assessments were available which contained information about potential risks to people's health and safety. These included nutritional needs, skincare and mobility. Staff told us they read copies of people's care plans and risk assessments in their homes to make sure they understood how to keep them safe.

Staff told us they would report any accidents and incidents to the manager so that appropriate action could be taken. Four safeguarding concerns had been raised about people receiving a service since our inspection in August 2013. These related to the service people had received allegedly being so late and missed that people's needs were not met on a number of occasions. A local authority was also made aware of the allegations and investigated them under their own procedures for keeping people safe. Three of the allegations were substantiated showing people had not always been protected from abuse and harm.

The staff we spoke with had received training in how to keep people safe from potential abuse. The records confirmed they had recently received training in safeguarding adults. All the people we spoke with said they felt safe with the care staff who visited them in their home.

A safeguarding policy was available which staff were required to read as part of their induction. Staff were able to tell us how they recognised the signs of potential abuse and how to report it. Staff told us what whistleblowing in the work place was and what it meant for them. They knew it meant to report to someone in authority if they thought there was malpractice at work. We saw that the whistle blowing procedure had the contact information of who staff could report concerns to. However after our visit we

Inadequate

Is the service safe?

were made aware by senior staff from the head office that there was a more up to date copy of this procedure. The senior staff concerned told us an up to date copy was going to be made available for all staff.

There was a safe recruitment procedure to employ new staff and the required checks were undertaken before they were able to start work. Checks included written references and a Disclosure and Barring Service (DBS) check being obtained before new staff were able to commence employment. DBS checks are carried out to find out if people have been convicted of offences which may make them unsuitable to work in certain jobs including for domiciliary care agencies.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service in August 2013, we found shortfalls in staff supervision, regular meetings or observations where staff development and performance are monitored. The provider sent us an action plan telling us when they would make the required improvements by the end of November 2014. During this visit we found that these improvements had not been made.

People had not seen staff being supervised by more senior staff when they visited them at their homes. Staff told us they were not provided with any form of structured supervision of their work and performance. There was no supervision plan for staff and regular supervision sessions were not taking place. This meant that staff were not supported to provide effective care. The provider's policy was to carry out regular unannounced spot checks on staff when they were in people's homes. This was to check how they assisted people and to ensure they provided care that was safe and suitable. However, staff told us this was not being carried out regularly due in part to a shortage of staff. We saw records for three care workers that demonstrated they had an unannounced spot check when they were at work in the last six months. However this system was not up to date and spot checks had not been undertaken on the remainder of the staff team of over 20 people for between six months and a year.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A number of people told us how the unreliability of the service they received had impacted on their care. They also told us about the responses they received from the office when they rang up to find out where their care worker was. People told us; "it can be hit and miss whether you get a reply at all" "the office staff don't know what they are doing," and "you always get the same answer sorry but we have got lots of people off sick", "when I have rung the office to complain they are rude and tell me not to speak to them like that".

People spoke more positively about the way their care was carried out when staff did arrive for their visits. For example, one person said "my relative likes the carers" Another comment was "the carers are excellent".

Some staff told us they had been matched to the people they supported and were their regular care workers. Staff we spoke with demonstrated an understanding of the needs of people they regularly supported. People told us when they saw regular staff they felt they received a more effective service because they got to know the people who supported them and vice versa, because staff got to know their needs better. Other people told us they never knew who was going to turn up. One person said "I never get a list and I never know who is coming".

We found staff were not always able to effectively meet people's needs. For example, one person's care plan noted that they had four visits during the day from care staff to assist them with personal care, to have a meal cooked for them and to prompt them to take their medicines. We visited the person and when we there the lunchtime visit did not take place. This meant the person's personal care needs were not met and they were not assisted to take the medicines they required. The local authority had been made aware of a previous concern when this person's needs had not been met due to a visit not taking place when it should have. The person had been found in a distressed state. The very late visits to this person were corroborated by a monthly print out of all visits carried out from the 1 of October until the 31 October 2014. This print out was from the CM2000 electronic monitoring system, used with the local authorities to monitor care staff visits to service users' homes where care is funded by the local authority.

The way visits were planned and a shortage of staff meant there were regular occasions when people's visits were very late or missed which meant that people did not receive their care as planned. For example assisting with meals, administering medicines, or being assisted to dress and wash.

Staff understood about mental capacity and people's rights to make their own decisions and the principles of the Mental Capacity Act 2005. They told us how they respected people by offering and promoting people's rights to make choices in their daily life. They told us when people could not give consent and had been assessed as not having the capacity to make decisions they would discuss with a person's relatives or friend what they felt were their preferences in relation to personal care.

Staff were provided with an induction programme when they began working. The induction programme included training about different health and safety practices and procedures. Training records showed training was attended

Requires Improvement

Is the service effective?

by staff. Training courses included moving and handling, safeguarding adults and understanding the needs of older people. This was to help ensure staff had skills and knowledge to effectively meet people's needs.

Requires Improvement

Is the service caring?

Our findings

Not all staff treated people with respect. Some people told us on occasions they had found the office based staff “rude” and “disrespectful”. For example, one person told us they thought the office based staff had been dismissive when they had rung up to find out why their visit from a care worker was late. Another person said the office staff seemed patronising in their tone when they rang to find out why their visit had not taken place.

Every person we spoke with told us they were treated with respect and courtesy by care staff who visited them. People told us their regular care staff were, "absolutely superb”, “the staff are caring” “the carers are quite good” and “my regular carer is excellent” and “the carers are brilliant”. They also said care staff could never do enough for them and showed a willing attitude.

People said the care staff who visited them generally understood how to meet their needs. One person said, “my usual carers are brilliant and they make my life easier”.

Another comment was “the carers are reasonable and they are very good.” However the unreliability of the service people received meant the choices they made were not always respected.

People told us the care workers listened to them and would help them to express their views to the office staff about their care. However no one we spoke with said they were actively involved by the agency in making decisions about their care and support needs. This was confirmed by the manager and compliance manager. They told us to address this they were starting a review of peoples care and they were going to be consulting with individuals about their care and support needs.

We read information in some care plans which set out people’s preferences for when they reached the end of their life. The care plans which contained this information set out the care people wanted to receive so that if possible they could remain in their home and be comfortable at the end of their life.

The staff induction training included how to respect people’s privacy and dignity and what actions could be taken to put this into practice. Staff told us they had completed this induction process before they began work.

Requires Improvement

Is the service responsive?

Our findings

Some aspects of the service were not responsive to people's needs. Staff knew how to respond to complaints and understood the complaints procedure. A relative told us they had raised a concern and that the manager had addressed the matter. However, we found that not everyone knew who to speak with if they wanted to make a complaint. One person told us, "it keeps changing and I'm not sure who I would speak to". Another person said, "I've given up trying to complain."

We viewed the records of complaints made since we last visited in August 2014. The information we reads showed some significant delays had occurred when responding to complaints people had made. We read a copy of a complaint that had been made by a relative of service user. It was alleged that care records were not completed, care staff had left the person breakfast out of reach, the stair gate had been left open and their bed had been left 'wet' . Agency staff responded in a letter to the allegations made and apologised for them and stated that Carewatch agency had 'learned a valuable lesson'. This demonstrated that complaints were not picked up due to a lack of systems to monitor the quality of the service. The manager had responded to one recent complaint in a more prompt way and in accordance with the timescales of their own complaints procedure. However the other complaints had not been addressed in the timescales of the providers own procedure. This meant complaints were not properly responded to by the provider.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff we spoke with were knowledgeable about the people they visited and the care they required. Care records included information about the type of support people required and what actions to take to meet their needs. Staff knew what was recorded in people's records. Staff told us there were regular occasions when they were asked to support people who they did not normally see. They told us this meant it was hard to provide a personalised service. They also said they often had to change their rotas to assist other people who they did not know well or at all. They said they would ring the office and would read peoples care records to know what their needs were.

Some of the comments made by the people we spoke with reflected how the agency was not always responsive to their needs. One person told us, "a new young carer came; it took a long time to explain my needs". Other comments included, "some carers get to know you quite well but on the whole they move on" and "carers tell you they don't know who they are seeing until the last minute".

We saw that each person's needs had been assessed before they began using the agency. Two people's assessments had recently been reviewed to show they were up to date and gave accurate information about the support each person required. The assessments had been used to develop care plans which had information for staff about how to support each person to meet their needs. The care plans included information about the person's life and their likes and dislikes. This meant staff had access to information about people's care needs. However we found that the majority of assessment records were not being regularly updated to show they accurately reflected the support people required.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in August 2013, we found shortfalls in the systems used to assess and monitor the quality of the service. The provider sent us an action plan and told us they would make improvements by the end of November 2014. At this visit we found that the systems were still not operational and improvements had not been made.

The quality of service received by people was not effectively monitored. We saw a system was available that could be used to carry out surveys of people who used the service by telephone or by visit them but this had not been implemented. The office staff told us these had not been kept up to date and had not been carried out since before 2012. One person told us the manager had been to see them because they had some concerns about the reliability of the service they were receiving. The person also told us the manager spoke to them and addressed their concerns at the time.

We saw the provider had systems which could be used for monitoring the service to check it was safe and suitable. However these were not effective because they were not being kept up to date or fully implemented. For example, we identified some medicine administration omissions that were not picked up by as there was no audit system set up to do this. This meant there was a failure to quality check whether people were being assisted and prompted to take the medicines they required.

The manager told us there were no formal records or reports made after the provider visited to identify areas for improvement or good practice. The manager did not have information about the quality of the service to make improvements where needed.

None of the 13 services users who we spoke with and asked during the inspection told us they had been involved in their care package being reviewed by the agency.

The time care staff spent with people who used the service was monitored. The agency used the online system known as CM2000 to record the times staff arrived at people's homes. It was also used to monitor the time they completed their visit. The manager explained that they found the monitoring system useful. They said it was a way of tracking if people's visits were completed properly. The records we saw confirmed the feedback from the people we spoke with. Over the last six to nine months there had been an increase in the number of late and missed visits.

Incidents and accidents that included missed and late visits were not being evaluated to learn from what had taken place. This meant that risks and ways to improve the service were not consistently being identified and acted upon. We saw that incidents and accidents which had involved people who used the service were documented. We looked at a sample of records from the last six months. We saw that the manager had commenced keeping their own record of missed and late visits in order to monitor the numbers and reasons for these occurring. However there was no evidence of evaluation and learning after any incidents or accidents to resolve problems and make improvements. This meant there was a lack of assurance that people were receiving a service that was suitable and met their needs.

This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

The manager was supported in their role by two other staff with management responsibilities. The care staff told us office staff were available for advice. However care staff said they were not provided with consistent management support. Staff reported their morale was low because of the lack of management support. Staff also reported that staff meetings were not held regularly.

People who used the service were not clear about the structure of the management team and also had some negative views of the office staff. One person told us, "they don't know what they are doing." Another comment was, "I complained but you can never get hold of any managers". One person commented positively about the new manager and said, "she came to see me and for a while things were better". A further comment was, "the only proper contact we have with the agency is with the carer we see every day".

Staff and some of the people we spoke with told us there had been recent changes to the management structure of the agency. They said it was not always clear among the

Inadequate

Is the service well-led?

management team who had management responsibility for different aspects of the service and the way it was run. The staff told us regular staff meetings were not taking place. This was confirmed by the managers.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People were cared for by staff who were not being consistently supported to deliver care and treatment safely and to an appropriate standard.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints People had not all been made aware of how to raise complaints and complaints were not being responded to in a timely manner.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.

The enforcement action we took:
Notice Of Decision to restrict any further Service Users being taken on by the Agency or any increases in the packages of care for current service users

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not have effective systems in place to monitor the quality of the service delivery.

The enforcement action we took:
A Warning Notice