Civicare Midlands Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 10 and 11 September 2015 and was announced. At our last inspection completed on 14 January 2014 we found three breaches in regulation. At the inspection completed on 10 and 11 September we found the provider had made improvements, however, they were not always meeting the regulations.

Civicare Midlands Ltd is a domiciliary care agency that is registered to provide personal care and nursing care. The provider was not providing a service to people under their registration for nursing care at the time of the inspection and a registered manager for this regulated activity was not in place. There was a registered manager in place for the regulated activity of personal care. The registered manager advised that at the time of the inspection they were providing support for 48 people who lived in their own homes. 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.

Summary of findings

People were not supported by staff who had always had robust recruitment checks completed before they started work. The provider had not sufficiently completed all required pre-employment checks for all care staff.

People were happy with the support they received with their medicines and told us that they received them as prescribed. Systems were not in place to record the administration of people's medicines. People were not always protected through effective risk management. Risk assessments were not always in place and risks to people had not always been identified and mitigated.

People told us that they felt safe while using the service. Staff could tell us how they would identify and report concerns about people, however, we identified concerns during the inspection that had not been reported appropriately.

People who had the capacity to provide consent for their own care confirmed that staff obtained their consent before supporting them. Staff and managers did not understand how to obtain consent where people may have reduced capacity. The principles of the Mental Capacity Act 2008 were not understood by the provider or applied.

People felt most staff had the skills needed to support them effectively. Staff felt supported in their work and told us that they received training. We found that where staff needed specific skills to support people with conditions such as dementia and epilepsy staff did not always have these skills and had not received appropriate training.

People told us that they were happy with the support they received with their food and drink. We saw that staff had made contact with some outside healthcare professionals where extra support was needed.

People told us that they felt care staff were caring and sensitive to their needs. People told us that care staff knew them and respected their preferences around their care. They told us that they didn't always feel that their preferences were obtained by the provider. People felt they were treated with dignity and respect by care staff and that their privacy was protected.

Care plans were not always person centred and reflective of people's needs and preferences. The care manager was not always aware of people's needs. Care plans were not regularly reviewed and updated to reflect people's changing needs. Some people felt that care staff provided the support that they needed. Other people told us that they didn't always have their preferences sought and respected by the provider, in particular the times at which their care was received.

People did not always feel able to make a complaint to the provider and felt their complaint wouldn't be listened to by managers or office staff.

The provider had not developed effective systems to monitor the quality of service provision, to identify risks to people and to mitigate these risks. Accidents, incidents and complaints were not monitored to ensure that risks to people were mitigated and improvements to the service made. Records relating to people's care were not always reviewed, kept up to date and did not reflect decisions made about their care. The provider had no systems in place to ensure that people received their care visit at the time they wanted it.

The provider and the care manager were not always aware of their obligations and responsibilities by law. People did not always provide positive feedback regarding the management of the service. Staff told us that they were happy with managers and that they felt fully supported in their roles.

We found that the provider had breached regulations within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not always safe.

People were not always protected by safe recruitment practices. Staff told us that they were aware of how to identify concerns about people, however these concerns were not always reported.

People told us that they received their medicines as prescribed although this was not always recorded appropriately. People were not always protected by robust risk management systems.

We did not inspect the regulated activity of nursing care as there was no service being provided at the time of the inspection.

Is the service effective?

Requires improvement

The service was not always effective.

People were cared for by staff who felt supported in their roles. Staff had not always received training to support people with specific needs.

Staff and managers were not aware of how to obtain consent from people where they lacked capacity to consent to their own care. People were happy with the support they received with their food and drink.

We did not inspect the regulated activity of nursing care as there was no service being provided at the time of the inspection.

Is the service caring?

Requires improvement

The service was not always consistently caring.

People felt that they were supported by a team of committed and caring care staff.

People's personal preferences were taken into account by care staff, however people did not feel that management were aware of their preferences. People's dignity and privacy was upheld and protected by care staff.

We did not inspect the regulated activity of nursing care as there was no service being provided at the time of the inspection.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans did not always reflect their needs. People didn't always have their choices respected around the time they wanted to receive their care.

People did not always feel able to complain to the provider and told us that their complaints were not always responded to appropriately.

Summary of findings

We did not inspect the regulated activity of nursing care as there was no service being provided at the time of the inspection.

Is the service well-led?

Inadequate

The service was not well led.

People were not supported by a provider who had systems in place to monitor and manage risks and make improvements to the service people received.

People did not always provide positive feedback about the management of the service. Managers were not always aware of their responsibilities under current legislation.

We did not inspect the regulated activity of nursing care as there was no service being provided at the time of the inspection.

Civicare Midlands Ltd

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 10 and 11 September 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.'

The inspection team consisted of one inspector and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. As part of the inspection we reviewed the information we held about the service. We reviewed information that had been sent to us by the public and the local authority. We were aware that there had been several complaints during 2015 about the timing of people's care visits, including missed care visits. We also looked to see if the provider had sent statutory notifications about important events which the provider is required to send to us by law. We used this information to help us plan our inspection.

During the inspection we spoke with eleven people who used the service and four relatives. We spoke with six members of care staff, the care coordinator, care manager and registered manager. We reviewed records relating to medicines, three peoples care and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People were not always protected from potential harm due to the provider not completing all required background checks for new care staff. We checked the provider's recruitment procedures and found that the appropriate criminal history checks had not been completed for some care staff that were currently employed at the service. The provider had completed a basic criminal history check for these staff members. They had not completed an enhanced check which is required for people working in care. The provider confirmed that they would arrange for these checks to be completed as a matter of urgency. We found that the provider had completed all other required recruitment checks.

We reviewed how people were kept safe through risk management. We found that risk assessments were not always present in people's care plans, they were not always up to date or they did not accurately assess the risks to people. For example, one person was identified as having a low risk of developing pressure ulcers despite them being cared for in bed and being assessed as incontinent. Care staff that we spoke with were not aware of the potential risks to this person. The provider confirmed that that not all accidents and incidents involving people using the service were recorded. The provider said that they addressed issues as they arised and they are not always recorded as their "system would be overwhelmed". The provider wasn't managing the risks to people through a reliable system of analysing accidents and incidents and reducing potential risk.

Some people told us that staff assisted them to take their medicines. People told us that they were happy with the support they received with their medicines and that they received their medicines as prescribed. People's care records did not allow for care staff to accurately record the support that was being provided with medicines. Staff were not aware that they were not correctly recording the administration of medicines.

People told us that they felt safe while using the service. One person said, "I am safe with them. I have nothing to worry about". Another person said, "I can trust that they will not hurt anyone". People felt confident in who they would approach if they had any concerns about potential abuse. Staff understood what abuse was and what the potential signs of abuse were. They told us that they understood how to report abuse if they saw it. The provider had not reported any safeguarding incidents to the local authority. We identified concerns during the inspection about people that we reported to the local authority. These concerns had not been identified by staff or managers within the service. The provider told us that if they were dealing with a safeguarding incident they did not understand the requirement for this to be reported to the local authority also.

The registered manager told us that the number of staff required to support people effectively and safely was determined by the local authority. Where people paid for care privately the registered manager advised that there was a system in place for assessing people's needs and identifying how many staff were needed. People and staff told us that there were sufficient numbers of care staff to meet people's needs. We identified some concerns around the times that people received their care visits however we did not identify concerns with missed care visits during our inspection. The concerns that we identified were due to systems around scheduling and not the numbers of staff available.

We recommend that the provider refers to NICE guidance published 23 September 2015 "Home care: delivering personal care and practical support to older people living in their own homes."

Requires improvement

Is the service effective?

Our findings

At the last inspection we carried out on 14 January 2014 the provider was not meeting the regulation in relation to supporting workers. The provider submitted an action plan outlining how they would make improvements in this area. We saw that improvements had been made in this area.

People said that they felt most staff had the right skills to support them. Staff told us that they felt supported in their work and that they were given the skills they needed to support people effectively. We were told by staff and managers that all new carers received an induction to the role and were required to complete the providers core training. This included online training in addition to practical training such as moving and handling. We saw a hoist situated in the office that was used for this training.

When we reviewed the training completed by staff we found that staff were not always adequately trained. We found that while staff were trained in safeguarding adults, they had not effectively implemented this training by identifying and escalating safeguarding concerns identified by inspectors. We found that staff were supporting people with specific needs such as dementia, epilepsy and pressure ulcers. Staff were not able to describe how to meet some people's specific needs and had not received training in these areas. For example, staff told us that they would change dressings on a pressure ulcer if they were covered in faeces. When we spoke to staff about their knowledge and training we were told that they had not received any training in pressure care and how to safely change a dressing. The care manager told us that specific training would be provided where care staff asked for this, however, additional training was not proactively provided in specific areas.

Staff and managers told us that they had a one to one or appraisal on a six monthly basis. We were told by both the staff and managers that they felt this was frequent enough to ensure staff performed effectively as they had regular informal contact with managers. We were told by staff that they felt supported and that any issues that arose were dealt with immediately.

People told us that staff obtained consent before they provided any care for them. The people we spoke with were able to consent to and make decisions about their own care. We did not speak to people who had a reduction in their capacity during our inspection. Staff could describe how they would obtain consent from people who had the capacity to make decisions about their care. We asked managers and care staff if they were aware of their responsibilities in relation to consent for people who lacked capacity. The Mental Capacity Act 2005 (MCA) outlines these responsibilities. The registered manager and the care manager confirmed that they did not have adequate knowledge in this area.

Staff told us about three people who had reduced capacity due to dementia. We spoke to the care manager who was not aware that these people had reduced capacity. Staff were not able to tell us how to apply the principles of the MCA when people lacked capacity to make decisions for themselves. Care staff had not received training in how to support people with reduced capacity and how to obtain consent within the boundaries of this current legislation. Care staff told us that they would ask a family member if someone could not consent to their own care. The care manager was not able to confirm that these decisions were compliant with the requirements of the legislation as care plans had not been put into place regarding these people's specific needs.

People told us that they were happy with the support they received with their food and drink. People were encouraged to make choices around the food and drink they received. One relative told us "They help [person's name] with everything including feeding. They never put pressure on [person's name]." Another person said "They always give me what I like." Some people had support from their relatives in this area and therefore the provider was not involved.

Most people told us that they didn't require support with contacting outside healthcare professionals. We were told by most people that they did this themselves or they received support from relatives. Many people advised that they managed their own day to day health needs although required support from care staff for personal care. We saw that staff had made contact with GP's and social services in some cases where they felt additional support was required.

Requires improvement

Is the service caring?

Our findings

People told us that they felt care staff involved them in making decisions around their care, however, people didn't feel that there was sufficient involvement from the provider. One person's relative told us "Civicare, the office, have never paid a visit". We were told "If it wasn't for how highly motivated the carers were, it wouldn't be good."

The care staff that we spoke with demonstrated a passion for their work and told us how important it was to make sure people felt cared for and valued. They knew about the preferences and choices of the people that they provided support to although these preferences were not recorded in people's plans of care. People told us that they felt care staff involved them in choices around their care and listened to their views. One person said, "They know what I need". One relative told us that if [person's name] wanted their hair washed on a particular day the care staff would respond without question. The relative told us that they, "Can ask for anything" with the care staff. Staff told us that they took time to talk to people while they were providing support and listened to their choices. We looked at people's plans of care and found that people's choices weren't always recorded. The registered manager told us that as the staff team was quite small they were able to communicate these needs verbally therefore recording them wasn't always necessary.

People told us that they felt care staff were caring and sensitive to their needs. One person said, "The carers are wonderful and I've no complaints." Another said,"[Carer's name] and [carer's name] are really lovely, they're great." Another person told us, "I'm very satisfied with the care. I have the same carer every time and I know I've got someone I can rely on." One relative told us, "The [carer's] were wonderful to my [relative]." Care staff told us that if they had any concerns about people they felt they could contact the office and someone would respond quickly in order to ensure people's needs were met. Some people told us that they didn't feel staff in the office were as caring as the staff who provided their support.

People told us that they were treated with dignity and respect by the carers. A relative told us that they respected one person's needs, "without a doubt". Another relative told us that when [person's name] had recently passed away that care staff "were brilliant". They told us "they still treated [person's name] with a lot of dignity. They supported me." Staff told us that they tried to protect people's privacy and dignity. They told us that they would shut doors and ensure privacy while they were completing personal care with people. Staff told us how they would maintain people's confidentiality to protect their dignity. We were given some specific examples of how staff would protect people's privacy and dignity for certain people they supported with specific medical needs, for example incontinence. One relative told us that they had to ensure that one person using the service was dried properly once carers had left. They told us that their relative was sometimes left damp and not sitting in a comfortable position. They did not indicate if the provider had been informed about these concerns.

Requires improvement

Is the service responsive?

Our findings

At the last inspection we carried out on 14 January 2014 the provider was not meeting the regulation in relation to care and welfare of people using the service. The provider submitted an action plan outlining how they would make improvements in this area. We found that the provider had begun to make improvements in this area.

Some people told us they didn't always have their preferences taken into account regarding the time they received their care visits. One person said, "We never know who is coming in tea time, though we have more regular ones in the morning. They come very late in the evening, sometimes as late as 9pm when they are supposed to come by 6-7pm." Another person told us that they don't get their morning call at the time they wanted it. They said, "That can be a bit of a problem if I'm just lying there." One person said, "They keep changing the carers and messing everything up." The registered manager told us that the care staff identified the times at which care visits were completed based on people's preferences. They did not identify that there was a problem with people receiving their care visits at the time they wanted them.

We found that care plans didn't always reflect the needs of the person using the service. The registered manager told us that they did not complete their own assessment of people's needs when they received a referral from the local authority. The registered manager told us that care staff would start providing care for someone and they would identify their needs during the visit and report the person's needs to the office. When we spoke to care staff they confirmed with us that they found out about people's needs by speaking to the person and their relatives. One relative told us, "When we were placed with them [Civicare], they should have done a site visit. The plan is based on what the carers tell them."

We identified that care staff were providing support to people with pressure ulcers. The care staff told us that they were required to turn one person each time they completed a care visit, however, this requirement was not recorded and outlined in their plan of care. We were told by staff that any changes in people's needs were reported to the main office for the manager to address. We found that care plans were not updated to reflect these changing needs. For example, one person's circumstances around their support at home had changed. We were told by staff that this person had regular seizures and we saw that seizures were recorded in this person's daily records. There was no evidence in this person's care plan that any changes in their needs had been identified, managed and escalated appropriately. We asked the registered manager what the reasons were for this person not having a revised care plan or their plan including information about their medical condition. The registered manager was not aware that they needed to create a care plan for these needs. We spoke to staff about the care they provided to this person when they had a seizure. Staff confirmed that they did not have a clear understanding of the actions to take if a seizure occurred. We were told "If it's bad then we should get an ambulance."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations) 2014.

People told us that they did not always feel able to complain to the provider. One person told us, "I don't like to talk to no one. I don't like complaining." Another person told us, "If you ring and complain, we just get told they're doing their best." Another person said that they'd raised a complaint and told us, "We complained but they did not do anything about it." We asked to see records of the complaints that had been made into the service. We saw that some complaints were logged on a database as having been received. The provider had not recorded the investigations into these complaints and the outcomes. Office staff could, however, describe the outcome of complaints when asked.

The registered manager told us that they had stopped issuing feedback surveys to people who use the service as they receive regular informal feedback and this is always addressed immediately. One person told us that they weren't proactively encouraged to provide feedback about the service. Another person told us that they didn't always feel comfortable providing feedback.

Inadequate

Is the service well-led?

Our findings

At the last inspection we carried out on 14 January 2014 we found that the provider was not meeting the regulation in relation to assessing and monitoring the quality of service provision. We received an action plan from the provider which outlined how they would make improvements in this area. The provider had not made sufficient improvements in this area.

The provider had not developed effective systems to monitor and assess the quality of the service and care being provided and to mitigate risks to people. At the time of our inspection there had been no audits completed on care records or quality since October 2014. We found that events such as accidents, incidents and complaints were not monitored. As a result, actions for improvement as a result of these events could not be evidenced and risks to people could not be managed effectively. We were told by the provider that there were currently no systems in place to record outcomes of these events or to monitor them for any trends or actions to mitigate risks within the service.

We saw that daily care records were being reviewed by a member of staff in the office, however, there was no evidence of these care records being reviewed by a manager or of issues being identified and escalated to managers. The provider was not able to provide evidence that they had recently completed checks on the quality of care records and in turn the care provision people using the service received.

The provider was not able to demonstrate that they had systems in place to identify people's changing needs and to update care plans in order to manage the risk to people and ensure they received good quality care. Records relating to people's care were not always up to date and did not reflect decisions made about their care. The provider advised that as they had a small care team they often relied on verbal communication regarding people's needs and details were not always recorded. There was no system in place to regularly review the care provided to people, proactively identifying issues or changing needs and risks.

The provider did not ensure that effective communication was always in place to mitigate risks and ensure people received good quality care. Care staff advised us during the inspection of specific health and well-being needs of people. When we discussed these needs with the care manager, we were either told that the views of the care staff were inaccurate or we found that the manager was unaware of these needs. The care manager had overall responsibility for ensuring that people's care was delivered in accordance with their needs and care plans were up to date. We found that the provider had implemented a new care plan structure to address concerns following our last inspection. Not all care plans had been transferred to the new structure which meant that the concerns raised at the previous inspection had not been fully addressed and risk assessments were not always present.

The provider had not ensured that safe systems were in place to mitigate risks to people when recording their medicine administration. At our last inspection we identified issues with staff and managers effectively identifying when their support with people's medicines became administration of medicine. We found that this practice was continuing at the inspection completed in September 2015. Staff and managers told us that they were prompting people, however, staff described to us a process of the administration of medicines. The providers policy around the management of medicines provided staff with a conflicting definition of medicines administration compared to their new guidance in care plans around medicines support. The provider had not ensured that they had systems in place to record the administration of medicines. The provider had also not ensured that they had systems in place to review medicines records to actively identify and mitigate risks to people.

The provider had not developed systems around the management of staff rotas and the times of people's care visits. Staff rotas did not reflect the care visits actually being completed by staff. The provider had implemented an electronic call monitoring system called CM 2000 however this was being used solely for financial management. The provider confirmed that there was no system currently in place for knowing exactly where care staff were and if they were attending calls on time and for the correct duration. The rota produced by the office did not reflect travel time required to get between each call and in some cases outlined that multiple care visits needed to be completed at the same time. We had been informed of complaints to the local authority regarding call time prior to our inspection. The provider was aware of these complaints

Inadequate

Is the service well-led?

but had not taken sufficient steps to resolve these concerns and improve the service provided to people. People informed us that they weren't always happy with the time at which they received their care during the inspection.

The provider and the office staff informed us that care staff had a list of care visits that they needed to complete. We were advised that care staff would identify with people directly when they wanted their call to be completed and this was not recorded in the rota. The provider did not have a system of recording at what time people wanted to receive their care visit. The provider also did not have a system of monitoring to ensure that people received their care visit on time. The provider was not monitoring the quality of service provided to people and was not identifying and mitigating risks both to people who used the service and to staff.

The provider was not always aware of their requirements under current legislation in order to mitigate the risks to people and to keep people safe while providing care. The provider and registered manager were not aware of their responsibilities around notifying the local authority of concerns about people's safety and well-being. The provider also had not ensured that staff were able to effectively identify these concerns and report them. The provider and registered manager had also not notified ourselves of significant events that they are required to do by law.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

One person told us that they weren't aware of who the managers were within the service. Another said that they weren't happy with the management of the service. We were told by one relative "There's no communication between the office and ourselves", "if it wasn't for the carers, that place would crumble." Staff told us that they felt the managers and office team were very good and they were happy with the support they were given. Staff said that they felt if they raised an issue or a concern then this was responded to immediately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care People's care plans did not always reflect their personal needs, preferences and changes to these needs. People's preferences were not sought and respected regarding the time at which they received their care.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not developed systems that ensured risks to people were mitigated and the quality of the service provided was monitored and improved.