Review of compliance

Charter Care (West Midlands) Limited Charter Care (West Midlands) Limited	
Region:	West Midlands
Location address:	84 Birmingham Street Oldbury West Midlands B69 4EB
Type of service:	Domiciliary care service
Date of Publication:	September 2011
Overview of the service:	This is a domiciliary care agency that is registered to supply personal care to people in their own home. The agency offices are located in the Borough of Sandwell.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Charter Care (West Midlands) Limited was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 19 August 2011, checked the provider's records, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We spoke with people and relatives over the telephone as part of this review. Overall people were happy with the times of their calls and the staff providing their care. Nobody we spoke with had experienced a missed call in the last 12 months. All staff are reported to wear uniforms and use gloves and aprons. This is to reduce the risk of cross infection.

People told us that they were involved in their care planning and regular review. They told us that their care workers made them feel safe and knew how to provide their support. All of them said that if they had any concerns they would speak to the office. They felt by doing this, there issues would be listened to and resolved.

What we found about the standards we reviewed and how well Charter Care (West Midlands) Limited was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People are involved in developing their care packages and their privacy and dignity is maintained.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People using the service have a plan of their care needs and people are involved in

planning their care. Some important pieces of information are not always recorded.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People using this service have their rights are respected and get the support they need to stay safe. However if staff knowledge is not updated, there is a risk that abuse may go undetected and unreported.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People are supported by staff who receive regular support and training to do their job safely.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People cannot be assured that quality and monitoring activity will inform and underpin effective improvements to the service.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

People cannot be confident that important events which affect their welfare, health and safety are being consistently reported to the Care Quality Commission.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Everybody we spoke with told us that they had been involved in their assessment and care plan. One relative told us how the staff always promote her relative's privacy and dignity.

One person described how she likes to do as much for herself as possible and the care workers respect and encourage this.

We were told that that somebody from the agency comes out to review them regularly. They also told us that occasionally a senior staff member will arrange to observe the staff providing care (with the person's permission) to make sure they are doing it properly and safely.

People told us that all the staff that visited their homes were respectful of their property,and to them. They were able to give examples of how their privacy and dignity was maintained whilst they were receiving personal care such as bathing or washing.

Other evidence
We saw that key documents had been signed by the person when the plan of care was being agreed and completed. We spoke to relatives who told us that they were included

in the assessment and review process where this was appropriate.

The staff member we spoke to was able to give us some good examples of how they promote privacy and dignity whilst providing personal care. They told us they always try to keep the person covered, shut doors and close curtains.

Currently there is little information in the care plan about maintaining a person's privacy and dignity. This should be included as part of the care planning process to show how this is being considered as part of the overall care package.

Our judgement
People are involved in developing their care packages and their privacy and dignity is maintained.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with people and relatives over the telephone as part of this review. Overall people were happy with the times of their calls and the staff providing their care.

All staff are reported to wear uniforms and use gloves and aprons to reduce the risk of cross infection (these are sometimes referred to as personal protective equipment).

When questioned nobody felt that their care worker rushed them. A couple of people commented that the continuity of care workers for the weekends and some nights could be better. The agency has already identified as a result of the surveys recently undertaken.

People/relatives said about their care worker:

"Fine really – she is very helpful"

"They are lovely with my mom"

"Majority of the care workers are very good, in fact I would say exceptional"

Other evidence
We looked at three care plans. These should give staff information about a person's needs and how to deliver their care safely. Each person had a plan of care. We could see that the person had been involved in developing these as they had signed them.

There was also evidence that these plans were subject to regular review. Other documents such as information from the local authority (where the care was funded by them), task sheets and a needs assessment were also available.

Each care plan identified objectives and outcomes which were generally to maintain the person's independence within their own home. The plans then identified tasks relating to the call. Generally, whilst we could see the main tasks for each person's call, there was limited details about how that person would like their care to be delivered or their personal routines. This is sometimes called person centred planning and is good practice.

We looked at a number of risk assessments. These assessments should provide staff with information about how to promote people's independence and ensure their safety where risks have been identified. We found gaps in the risk assessments. For example none of the risk assessments gave staff instructions on how to move the person safely. We saw one record which listed two types of sling to be used for the hoist, but there was no direction to the staff on which one to use for which task. For another person consideration had been given to a previous history of falls, but this could have been further explored and expanded upon to minimise the risks of further accidents.

We have been told that an improvement notice has been issued by the Health and Safety Executive to this provider for an accident which occurred in the Wolverhampton Branch. We have received verbal assurances that improvements in the documentation will also be implemented within the Sandwell Branch.

Our judgement
People using the service have a plan of their care needs and people are involved in planning their care. Some important pieces of information are not always recorded.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
When we spoke to people on the telephone, all of them were able to tell us how the staff kept them safe for example, making sure the doors and windows were locked on leaving the call.

All the people we spoke with told us that if they had any concerns or problems they would speak with the staff or the office directly. They told us that the felt action would be taken. One relative told us "the manager Mark is excellent, if we have any problems, we pick up the phone and he sorts it".

Other evidence
The agency confirmed that they have access to the multi-agency safeguarding procedures for Sandwell.

The manager was able to clearly identify how he would respond and act on any allegations of abuse.

We spoke to the safeguarding team in Sandwell who told us that since December 2010 they had received two referrals from this agency. This demonstrates that the manager has acted appropriately. However they have not notified us of these referrals which they are required to do by law.

We had mixed responses from the staff about their knowledge in relation to safeguarding people. One staff member told us that they knew about the different

types of abuse, but when questioned further could not give us examples. When we offered financial abuse as a prompt to the staff member, they told us that they did not think that this area was covered as part of the training. This raises concerns about the quality of the training being provided. Another was able to show a good understanding of adult abuse and gave a clear account of her responsibilities for reporting any incidents to the manager. She felt that action would be taken.

Staff receive training internally from within the company. We highlighted shortfalls in the trainer's knowledge whilst undertaking a review at another location. The manager for the Sandwell branch told us that an external agency is to be used to provide refresher training to all staff.

Our judgement
People using this service have their rights are respected and get the support they need to stay safe. However if staff knowledge is not updated, there is a risk that abuse may go undetected and unreported.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak about training directly with people, however people did feel that their care worker had an understanding of their personal care needs.

Other evidence
The agency has a range of systems in place to support the staff.

They have an induction programme which is reported to meet the Skills for Care specification. This is managed by one of the office workers within the Wolverhampton office. We saw an example of a recently reviewed induction. This had been forwarded back to the Sandwell branch as it was incomplete. This shows that records are being checks and gaps identified. In addition to the induction, all staff undertake hoist training as a minimum prior to making any calls. During this time they also undertake a programme of shadowing with a more experienced member of staff. We saw good evidence of this on the files we looked at.

The agency does organise office supervisions, community supervisions and spot checks. We saw evidence of these on each of the staff files we looked at. Staff told us that they are subject to reviews regularly. We were also told that the manager had an open door policy which means that he is available and accessible to the staff team.

There is a training matrix which covers the whole staff group. We have been advised that training was put on hold for one month but this is now being rolled out again. In addition we have been advised that the senior care workers are going to attend person centred planning training which will help them in delivering the changes to the care

plans.

Our judgement
People are supported by staff who receive regular support and training to do their job safely.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People told us that they receive regular contact or visits from the office and this was consistent for all the people we spoke with. People did not know the outcome of the surveys they completed.

Other evidence
We asked the provider to submit information to us about the systems they have in place to monitor the quality of service. They told us that they have a range of tools to help them monitor the quality of the service they provide. These include information giving, observation of care, and reviews of care plans. Risk and needs assessments are also completed and reviewed regularly as part of the overall individual care package. Supervisions, spot checks and quality monitoring visits all form part of this process.

An annual survey is sent out to people who use the service. We asked the provider how they used these surveys. They told us they analysed the results and used them for business purposes for example when applying for a new contract. They currently do not share the results with the people who use the service.

During our discussions the manager confirmed that there were no audit systems in place for monitoring how and whether these processes are being used. We also highlighted that the agency is not using key information such as complaints or accidents as part of the quality monitoring processes. These can be particularly useful in identifying trends or patterns to inform future service development.

The provider has started to complete the documents provided by the Care Quality Commission. These are called provider compliance assessment forms. They are a way for the provider to show how they are measuring compliance with the standards. Where there are shortfalls, the assessment form gives the provider an opportunity to complete an action plan. This was not fully completed at this review but will be a very useful tool in helping the provider to prioritise areas for action over the forthcoming months.

Our judgement
People cannot be assured that quality and monitoring activity will inform and underpin effective improvements to the service.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are minor concerns with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
We did not speak to people directly about this outcome group.

Other evidence
As stated earlier in this report, the provider has failed to notify us of safeguarding incidents in line with their responsibilities for reporting to us under Regulation 20 of the Health and Social Care Act 2008.

The manager has acknowledged the recent gaps and has assured us that he will notify us in future.

Our judgement
People cannot be confident that important events which affect their welfare, health and safety are being consistently reported to the Care Quality Commission.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People using the service have a plan of their care needs and people are involved in planning their care. Some important pieces of information are not always recorded.	
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People using this service have their rights are respected and get the support they need to stay safe. However if staff knowledge is not updated, there is a risk that abuse may go undetected and unreported.	
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: People cannot be assured that quality and monitoring activity will inform and underpin effective improvements to the service.	
Personal care	Regulation 18 CQC (Registration)	Outcome 20: Notification of other

	Regulations 2009	incidents
	How the regulation is not being met: People cannot be confident that important events which affect their welfare, health and safety are being consistently reported to the Care Quality Commission.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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