Review of compliance

Charter Care (West Midlands) Limited Charter Care (West Midlands) Limited (B69)	
Region:	West Midlands
Location address:	84 Birmingham Street Oldbury West Midlands B69 4EB
Type of service:	Domiciliary care service
Date of Publication:	February 2012
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 (B69) was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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 to check whether Charter Care (West Midlands) Limited (B69) had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 20 - Notification of other incidents

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 3 February 2012 and talked to staff.

What people told us

We carried out this review to check on the care and welfare of people using this service.

We visited the agency offices as part of this review, and looked at information we have received about this provider since our last visit in August 2011.

We checked the systems for planning care, documentation and paperwork produced by the organisation.

We could see improvements in a number of areas for example in how we are being notified of incidents, the way safeguarding information was being stored, and in how risks are being managed. These improvements now need to be sustained.

The manager has continued to undertake an assessment of the service against the essential standards for quality and safety. They told us that they are going to employ an external consultant to ensure the process remained transparent.

One person who received a service from the agency said they had "no qualms at all". A relative told us how they were "really satisfied" with the care workers who visited their

relative.

What we found about the standards we reviewed and how well Charter Care (West Midlands) Limited (B69) was meeting them

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

Improvements in how information is being recorded means that people using the service have a plan of their care needs and how to manage risks safely. Improvements need to be continued and maintained.

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.

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 can be assured that the systems for managing the quality continue to improve, although not yet fully embedded.

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

People can 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. When we propose to take enforcement action, our decision 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 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

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
At the visit to the agency in August 2011 we found moderate concerns with care and welfare and how the organisation were managing risks.

As a result of this, we issued compliance actions and detailed how the regulations were not being met. The provider sent us an action plan telling us of the actions being taken to ensure compliance with the essential standards.

At this visit we checked to see if the actions described by the manager had been completed.

We spoke with a person who received a service from the agency and we also spoke with a relative. Both told us that they were generally happy with the staff and that the staff knew how to support them or their relative. One person said they are "good carers".

We looked at two care plans. These gave staff information about a person's needs and told them 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. The manager told us that he planned to review care plans more often alongside the newly developed risk assessments. 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. We saw that information about people's preferences had been included. This is sometimes called person centred planning and is good practice.

We saw improvements in the quality of information contained within the risk assessments, particularly relating to moving people safely. We saw detailed risk assessments and information for staff which gave them step by step instructions on how to move the person for different tasks, for example from bed to chair and vice versa. Where people had a history of falls, an assessment had been undertaken and included within the risk assessment. We spoke with a staff member who told us that the assessments were a lot more detailed and explained more about the person than before. They said these were "much better".

At the last inspection in August 2011 we knew that an improvement notice had been issued by the Health and Safety Executive to this provider for an accident which occurred in the Wolverhampton Branch. We have since received a report from the Health and Safety Executive to confirm that improvements had been made across both Sandwell and Wolverhampton branches. They confirmed to us that the notice had been met.

Other evidence
We did not have any other information at the time of reviewing this service.

Our judgement
Improvements in how information is being recorded means that people using the service have a plan of their care needs and how to manage risks safely. Improvements need to be continued and maintained.

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

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
At the visit to the agency in August 2011 we found minor concerns with how safeguarding was being managed.

As a result of this, we issued compliance actions and detailed how the regulations were not being met. The provider sent us an action plan telling us of the actions being taken to ensure compliance with the essential standards.

At this visit we checked to see if the actions described by the manager had been completed.

We knew from the last visit in August 2011 that the agency had access to the multi-agency safeguarding procedures for Sandwell. This meant they knew how to report incidents when they became aware of them.

At this and the previous visit, the manager was able to identify how he would respond to and act on any allegations of abuse.

Since the last inspection we saw evidence that all staff had received more training on abuse/safeguarding. This was run by the local authority. The staff member we spoke with confirmed that they had received training. They demonstrated a good understanding of abuse and what action they would take if any allegations were made to them.

We saw that information was being stored securely. Since the inspection in August 2011, the manager has notified us when allegations have been made.

Other evidence
We did not have any other information at the time of reviewing this service.

Our judgement
People using this service have their rights are respected and get the support they need to stay safe.

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

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
At the visit to the agency in August 2011 we found minor concerns with how quality was being managed.

As a result of this, we issued compliance actions and detailed how the regulations were not being met. The provider sent us an action plan telling us of the actions being taken to ensure compliance with the essential standards.

At this visit we checked to see if the actions described by the manager had been completed.

We knew that the provider had a range of tools which helped them monitor the quality of service they provide. Risk and needs assessments were 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 had recently been sent out to people who use the service. We saw the results of the last survey done in February 2011 which identified that generally people were happy with their care. We were told that if individual issues were identified on a questionnaire, senior staff would visit with the person to try to resolve any issues.

At this visit the provider had nearly completed 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. The manager told us that once these were completed, they were going to employ an external auditor to review the information. They told us that this would help them confirm their findings and produce an action plan for the future.

Other evidence
We did not have any other information at the time of reviewing this service.

Our judgement
People can be assured that the systems for managing the quality continue to improve, although not yet fully embedded.

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

The provider is compliant with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
At the visit to the agency in August 2011 we found minor concerns with how the organisation were reporting incidents to us.

As a result of this, we issued compliance actions and detailed how the regulations were not being met. The provider sent us an action plan telling us of the actions being taken to ensure compliance with the essential standards.

We checked to see if the actions described by the manager had been completed.

We found that there had been improvements in how the organisation has reported incidents. They have continued to provide us with updated information as required.

Other evidence
We did not have any other information at the time of reviewing this service.

Our judgement
People can 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

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Improvements in how information is being recorded means that people using the service have a plan of their care needs and how to manage risks safely. Improvements need to continued and maintained.	
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	Why we have concerns: People can be assured that the systems for managing the quality continue to improve, although not yet fully embedded.	

The provider must send CQC a report about how they are going to maintain 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 the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement 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
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