Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Charter Care (West Midlands) Limited (B69)

84 Birmingham Street, Oldbury, B69 4EB

Tel: 01215447600

Date of Inspection: 10 April 2014

Date of Publication: April 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✖ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Charter Care (West Midlands) Limited
Registered Manager	Mr Mark Casey
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.
Type of service	Domiciliary care service
Regulated activity	Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 April 2014, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members, talked with staff and took advice from our specialist advisors.

What people told us and what we found

We held telephone interviews with nine people that used the service; two relatives and we visited two people at home to talk to them about their experience. We spoke with the registered manager, deputy manager and three care workers. We considered all the evidence we had gathered under the outcomes we inspected. We used the information to answer the five questions we always ask:

Is the service safe?

Everyone that we spoke with said that they were safe with the staff that supported them. One person told us, "Yes, I feel safe with them. They always lock the door and make sure I am safe when they leave."

We saw that people had an assessment of their needs and associated risks. A plan of care was completed to enable staff to offer care and support to people in a safe way. Staff told us that they received training and support to enable them to offer care and support safely.

Staff spoken with told us that they knew how to raise concerns if they felt that people using the service needed to be safeguarded. The provider had policies and procedures in place to safeguard people that use the service and we saw that where issues of safeguarding matters have occurred the provider took appropriate actions to ensure that people using the service were safeguarded.

Whilst people told us that they always received their medication, we found that safe systems were not in place for the recording and administration of medication. A compliance action has been set in relation to this and the provider must tell us how they plan to improve.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. This is a domiciliary service and therefore this is not applicable.

Is the care effective?

People told us that they were receiving the care that they needed and they were happy with the care. One person told us, "Oh yes I have been with Charter Care for six years, I get morning and evening care. I am happy with the care and can't do without them."

Everyone that we spoke with told us that their care worker talked to them about their care and they always give their consent to being supported. One person that we visited told us, "We do things together and they do what I want them to do." However, we found that staff were making judgments about people's lack of capacity without showing how they had established this fact. Therefore people's rights were not adequately protected in line with legislation. A compliance action has been set in relation to this and the provider must tell us how they plan to improve.

Is the service caring?

Everyone that we spoke with told us that the care workers that supported them were caring. One person told us, "They are all caring and friendly." Another person told us, "They are respectful. I wouldn't have them otherwise."

Is the service responsive?

People that we spoke with told us that staff did what they wanted them to do. They told us that if their care workers were going to be late they were kept informed. One person told us, "If carers are going to be late they always let me know." A relative told us, "The service is good. They are very good with dad. They are regular and pleasant; they talk to him and treat him well."

Is the service well led?

We saw that the service had a staffing structure that would enable the service to be managed appropriately. This included a manager that we have registered to be responsible for the running of the service. People were consulted about the quality of service they received. Comments and suggestions were analysed to identify where improvements were needed.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 10 May 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone

number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, the provider did not act in accordance with legal requirements.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

All the people using the service that we spoke with told us their care worker always talked to them about their care and ask for their agreement to do things. One person that we visited told us, "We do things together and they do what I want them to do."

All the care workers that we spoke with told us that they always talked to people about the care before undertaking tasks. Some care workers confirmed that they have had Mental Capacity Act training and this was supported by the staff training records that we looked at. This meant that before people received care and support care workers asked for their consent.

One care worker told us, "I explain to people in a way that they can understand and will repeat things to ensure that they do understand. I always get consent from people. If I am concerned that they are not able to understand I report it to the office." However, one care plan and risk assessment that we saw stated that the person lacked capacity. There was no assessment in place to establish how this judgment had been made. A document which related to the individuals care had been signed by a relative indicating they were acting on the person's behalf. We asked the manager what process had been used to establish that the person lacked capacity, but he was unable to tell us. The manager did not clearly understand their responsibility to establish people's mental capacity if there were concerns about people's ability to make informed decision. The manager also did not know how to locate information about the Mental Capacity Act and the provider's responsibilities under the act. This indicated that if care workers reported concerns about people's capacity it was not clear that the appropriate action would be taken to ensure that people's rights would be protected.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We held telephone interviews with nine people that used the service; two relatives and we visited two people at home to talk to them about their experience. Everyone that we spoke with told us that they were happy with the care they received. One person told us, "Reliable service and very good carers. I am pleased with them" Another person said, "Oh yes I have been with Charter Care for six years, I get morning and evening care. I am happy with the care and can't do without them."

We looked at the care records of four people that used the service. We saw that all records contained a summary of the needs assessment completed by a social worker. We saw that care plans and risk assessments were available on each record. Since the last inspection the provider had introduced new procedures for care planning and risk assessments. These were seen to be an improvement on the previous procedures. We saw that people's individual needs were clearly reflected in the needs assessments, care plans and risk assessments.

At our last inspection we identified that care plans and risk assessments were not always available in people's homes to enable staff to provide safe care. The manager told us and we saw that procedures were now in place to ensure that a summary of each person's needs along with any key risks identified at the time of referral was placed in people's homes to enable the service to start quickly. Within a week of commencement of the service a senior care worker arranged to undertake an in-depth assessment of the person needs and any risks associated with providing the care and a full plan of care would be drawn up with the person and their relatives. Records that we looked at and staff spoken with confirmed that this procedure was in place. All the care workers that we spoke with confirmed that they now have the information to enable them to provide care in a safe way. Records that we saw in the homes of people that we visited also confirmed that care plans and risk assessments were available for staff to refer to. This meant that people's needs were appropriately assessed and planned to enable them to receive the care they need in a safe way.

At our last inspection we were told by relatives that people's care was not always reviewed when their needs had changed. During this inspection we saw that the provider had undertaken a programme of review as they had introduced new procedures, so people's

needs had been reviewed and updated. This ensured that staff had up to date information on the needs of the people they supported.

All staff spoken with told us that there was an on call procedure, and a senior member of staff was always available to give guidance in an emergency.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

All of the people that we spoke with said they felt they were safe with the care workers that visited them. One person told us, "Yes, I feel safe with them. They always lock the door and make sure I am safe when they leave." A relative told us, "Dad is safe with them."

The provider generally kept us informed of any matters of concerns that relates to the protection of people that used the service.

At our last inspection we found that whilst the provider had policies and procedures in place to safeguard people using the service from abuse, staff did not always follow the procedures to report and act on issues concerning people's safely and well-being. The provider sent us an action plan telling us that they would ensure that staff were updated on relevant procedures relating to safeguarding of people that used the service. During this inspection we checked what action had been taken to ensure that these failings did not re-occur. The manager told us that to date 70% of staff have had re-training on the whistleblowing procedure and their responsibility to report bad practice. All of the care workers that we spoke with confirmed that they had recently had this training. We checked the staff training matrix and we saw evidence to show that with the exception of one person, all care workers have had safeguarding adult training. This meant that the provider had taken action to ensure that staff were aware of the procedures and to ensure that people using the service were safeguarded from harm.

We spoke with a care worker who gave us an example where they had reported concerns about how people were being cared for and they confirmed that the managers had acted on the concerns. We saw from records that we looked at that where safeguarding incidents had occurred the provider had taken appropriate action and had ensured that the staff responsible were disciplined and referred to the Disclosure and Barring Service list. This meant that the provider took appropriate action to ensure that people were safeguarded from harm.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the care records of two people that required administration/ support with taking their medication. We saw that in both cases their medication needs had been identified in their needs assessment, included in their care plan and specific risk assessment were available which took into account any risks associated with this aspect of the person's care. We saw that whilst people signed their general risk assessments, care plans were not signed by them indicating their consent to be supported with taking their medication.

The two people that we visited in their homes both received support from care workers with taking their medication. They both confirmed that the care workers always ensured that they took their medication and that medicines were never missed. This indicated that people received their medication. Care workers spoken with said that they had received medication administration training. However, we saw no evidence that staff competence to administer medication safely was being monitored. This meant that whilst training was provided, the provider had no systems in place to check that staff remained competent to administer/ support people with their medication safely.

The records that we looked at showed that a medication administration record (MAR) was being used to record when staff had supported people with taking their medication. We observed that the MAR sheets did not specify the medication prescribed, but simply stated "blister pack", so you could not tell what medicines were being taken. Although a list of medicines were recorded on people's risk assessments, the method currently used for recording medication was not safe. One person's medication record that we saw when we visited them consisted of three different records. We were told that one record was for medicines taken from a blister pack, another record was for creams and ointments which were to be used as and when necessary (PRN) and the other record was for other oral PRN medication. We saw and the manager told us that there were no PRN protocols in place to support staff so they knew when to give these medicines. In addition when we asked to see other medication records in the office, they were not available as the deputy manager said they had not been collected for auditing. This meant that medication

recording was confusing and a clear system was not in place to check that people had received their medication as prescribed.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

All the people that we spoke with were satisfied with the standard of service that they received. One person told us, "Oh yes, I am more than happy with the service. No complaints at all. If they are going to be late they always let me know." Another person told us, "They are reliable and come as close to the time as possible." None of the people that we spoke with had experienced missed visits. This indicated that people were receiving a reliable service that they were happy with.

There was a complaints procedure in place and we saw that people were given information about how to complain within the information packs placed in their homes. People that we spoke with said they would call the office if they had any concerns. At our last inspection we identified that complaints were not analysed for trends, and that not all complaints were dealt with. During this inspection we sampled three complaints record and we saw that these had been fully investigated and responded to. We saw that the provider had introduced a system for analysing for analysing complaints quarterly. This showed outcomes and actions taken to improve the service.

At our last inspection we saw that there was a system in place for seeking people's views on the quality of the service. Information received from surveys were analysed, however, no action plan was in place to show how the provider would act on any short falls identified. During this inspection we saw that the provider had recently sent questionnaires to people that used the service to seek their views. A number of people that we spoke with confirmed that they had completed these questionnaires. These had been analysed and an action plan was in place to indicate areas where the service needed to improve. However, we did discuss with the manager that the action plan lacked detail, based on the issues that people had raised. A number of people that we spoke with confirmed that they had completed these questionnaires. This showed that the provider sought the views of people that used the service to help to improve the quality of the service.

At our last inspection we found that the systems for monitoring the service delivery were not effectively maintained. During this inspection we saw that new monitoring procedures had been put in place. Discussion with the manager present indicated that they had

identified other areas where they intended to improve the monitoring systems, so that they were more effective and should identify gaps where records have not been collected for auditing.

We previously found that staff conduct was not adequately investigated where concerns had been raised. During this inspection we saw clear evidence from disciplinary records that we looked at that this had been rectified. This ensured that any issues which related to the health safety and well-being of people using the service were now being appropriately addressed.

There was a management structure in place to enable the effective running of the service. This included a registered manager and a member of staff that would deputise in the manager's absence.

The provider is minded to note that there were no formal processes in place to enable staff to contribute to improvement in the service. Staff spoken with said they did not receive regular supervision and that no formal meetings took place to give them the opportunity to discuss service improvements.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Staff assumed that people did not have capacity to make informed consent without undertaking an assessment to establish this fact. Staff were not aware of the implications of the mental capacity act and people's rights within the act. This is in line with regulation 18 (1) (a) (b) (2).
Regulated activity	Regulation
Personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The current method used for recording medication was not safe. Records were not always available at the provider's office to demonstrate that people were receiving their medication as prescribed. Where people required medication as and when necessary there were no protocols in place to guide staff on how to ensure this was given safely. This is in line with regulation 13

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 by 10 May 2014.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk